Annual Disclosure of Ownership Overview

Purpose of the Annual Disclosure of Ownership (ADO)

- Required by Federal and State Laws and Regulations
  - 42 CFR 455.100 through 455.106
  - KRS 205.8477
  - 907 KAR 1:672

- Ensures the KY Medicaid Provider file is updated

Today's Overview

1. Due Date of ADO
2. Helpful Hints on Completing the ADO
3. Supporting Documentation (if applicable)

ADOs are due <u>ANNUALLY</u>

- Two “courtesy” letters are mailed out to the correspondence address on file prior to the due date:
  - 60-Day Letter
  - 30-Day Letter

No response letter sent notifying provider the agreement will end-date.

- Make a reminder for your records

Individual

INDIVIDUAL

ADO (Annual Disclosure of Ownership)
(Rev 05/13)

Annual Disclosure of Ownership (ADO) Instructions

Field #	Description
1	Enter name of individual or entity depending on who the ADO is in regards to.
2	Enter the KY Medicaid provider number.
3	Do you plan to have a change in ownership, management company or control within the next year? If so, when?
4	Do you anticipate filing bankruptcy? If so, when?
5	Enter the Federal Tax Identification Number (**if there is an affiliation with a chain**) along with name, address, city, state and zip code.
6	List name, address, SSN/FEIN of each person or organization having direct or indirect ownership or control interest in the disclosing entity. ***If no one owns 5% or more of provider, check box.*** If you are enrolled as an individual and do not own a FEIN, please enter your name and information. Corporate entities disclosed in this question must disclose every business location. ** IF A CORPORATE ENTITY IS DISCLOSED IN THIS QUESTION, THE BUSINESS LOCATIONS OF THE CORPORATE ENTITY MUST BE DISCLOSED. PLEASE ATTACH A SHEET TO DISCLOSE THIS INFORMATION.
Indirect Ownership Interest - means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. **Ownership interest** - means the possession of equity in the capital, the stock, or the profits of the disclosing entity. **Person with an ownership or control interest** - means a person or corporation that: • Has an ownership interest totaling 5% or more in a disclosing entity; • Has an indirect ownership interest equal to 5% or more in a disclosing entity; • Has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity; • Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or assets of the disclosing entity; • Is an officer or director of a disclosing entity that is organized as a corporation; or, • Is a partner in a disclosing entity that is organized as a partnership	
7	List officers' and board members' information of the disclosing entity. In the event, a sanction is returned for any names listed on this question, a SSN of the board member will be required.
8	If individuals disclosed in question 6, 7, and 17 are related, please list the relationship.
9	List name of management company. If not applicable, enter N/A. In the event, a sanction is returned for any names listed on this question, a FEIN will be required.
10	List names of the disclosing entities in which persons have ownership of other disclosing entities.
Other Disclosing Entity- means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes: • Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII). • Any Medicare intermediary or carrier. • Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX or the Act.	
11	If entity engages with subcontractors (such as physical therapist, pharmacies, etc.,) which exceeds the lesser of $25,000 or 5% of applicant's operating expense, list subcontractor's name and address.
Significant Business Transaction- means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of $25,000 or 5% of applicant's operating expense.	
12	List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year period. In the event, a sanction is returned for any names listed on this question, a SSN/FEIN will be required.
13	List name, SSN, address of any immediate family member who is authorized to prescribe drugs, medicine, devices or equipment.
14	List anyone disclosed in question #8 who has been convicted of a criminal offense related to the involvement of such persons or organizations in any problem established under Title 19 (Medicaid) or Title 20 (Social Services Block Grants) of the Social Security Act (SSA) or any criminal offense in this state or any other state. Please also indicate any KY Medicaid provider number(s) associated with individual or organization.

INDIVIDUAL

15	List any agent and/or managing employee who has been convicted of a criminal offense related to any program established under Title XVIII, XIX or XX of the SSA or any criminal offense in this state or any other state. Indicate any KY Medicaid provider number(s) associated with individual or organization. In the event, a sanction is returned for any names listed on this question, a SSN/FEIN will be required.
Agent- means any person who has been delegated the authority to obligate or act on behalf of a provider. **Managing Employee**- means a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.	
16	List the name, title, SSN, and address of all managing employees as defined in 42 CFR 455.101.
17	List name, address and SSN/FEIN of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.
Subcontractor- means an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients, OR an individual, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or lease of real property) to obtain space, supplies, equipment or services provided under the Medicaid agreement	
18	Please indicate which number you will be using for reporting monies to you from Medicaid for 1099 purposes. *Example: If you are an individual completing this question, please input your Social Security Number unless you are own a FEIN 100%. An individual provider can bill under his/her individual provider number even if they are working in a group setting. The individual must complete a Map-347 in order to be linked to the group setting under which they are reporting. **IRS verification letter or Social Security Card must be attached verifying FEIN/SSN.*
19	Enter your initials if you maintain electronic medical records and are HIPAA compliant. Check the box if you do not keep electronic medical records.
20	Please enter the contact information for DMS to contact should there be any questions regarding this form.
21	Signature: Enter original signature from the individual provider, owner, or officer/board member if the provider does not have an owner. If you are an individual provider, *your* signature is required. Printed Name: The individual signing this form must enter their printed name. Date: Enter the date this disclosure is signed. Title: Must be title of person signing this form. EXAMPLE: individual provider, owner, etc.
22	For Internal Purposes Only: DMS Authorized Signature

Please return form to:

KY Medicaid
P.O. Box 2110
Frankfort, KY 40602-2110

INDIVIDUAL

ANSWER ALL QUESTIONS!

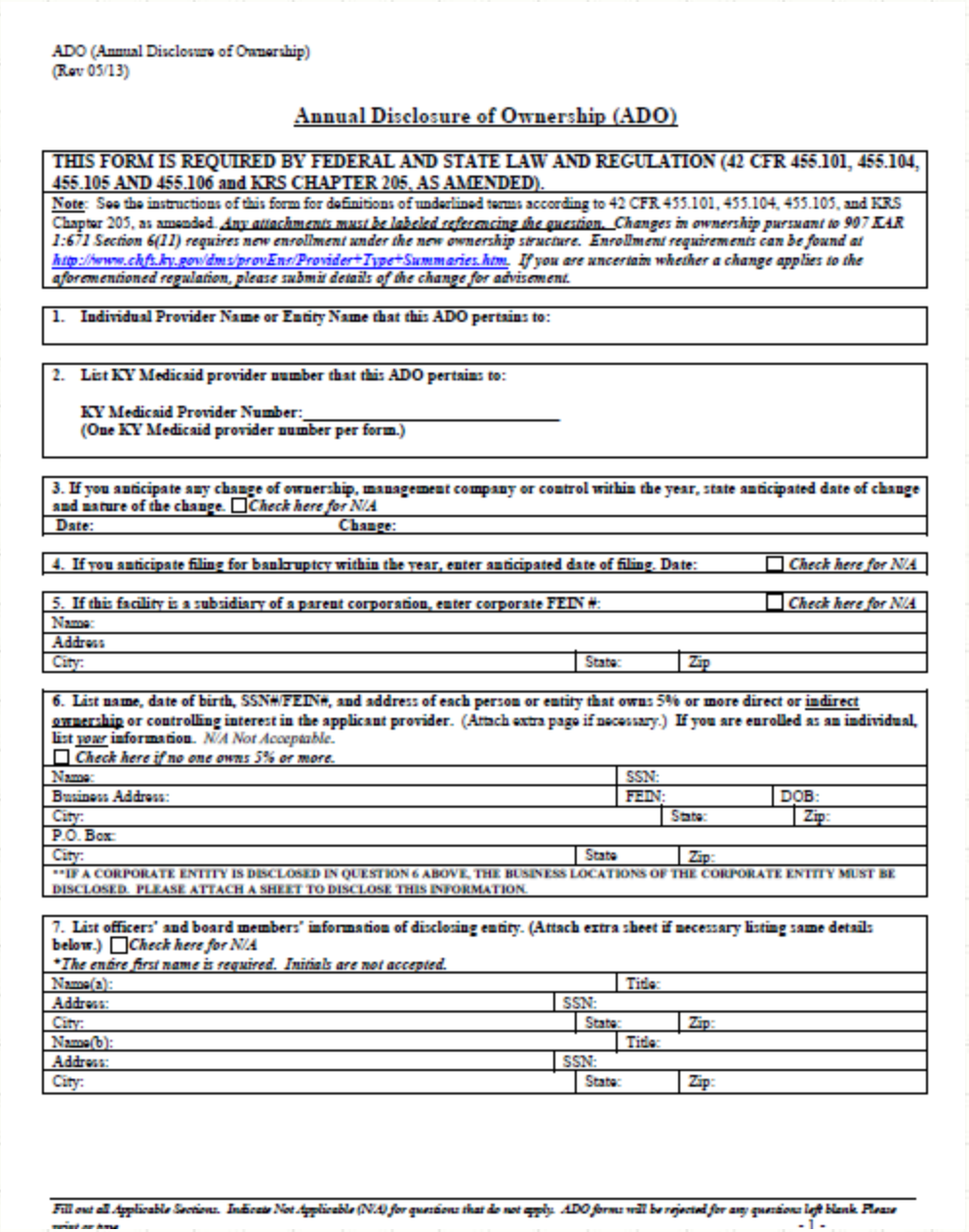
If it does not apply, be sure to indicate **N/A**. Many of the questions do not apply to an individual.

Do not answer a question and check N/A.

We cannot assume the answer. It must be complete.

Common issues:

- Question 1
  - Ensure your entire legal name is entered.
- Question 2
  - Ensure the number listed is the Medicaid provider number, for the individual provider that the form pertains to, and not the NPI, FEIN or taxonomy code.
- Question 6
  - List your entire legal name and complete each field with your individual information only.
  - N/A is not an acceptable response for an individual provider on this question.



ADO (Annual Disclosure of Ownership)
(Rev 05/13)

Annual Disclosure of Ownership (ADO)

THIS FORM IS REQUIRED BY FEDERAL AND STATE LAW AND REGULATION (42 CFR 455.101, 455.104, 455.105 AND 455.106 and KRS CHAPTER 205, AS AMENDED).

Note: See the instructions of this form for definitions of underlined terms according to 42 CFR 455.101, 455.104, 455.105, and KRS Chapter 205, as amended. *Any attachments must be labeled referencing the question. Changes in ownership pursuant to 907 KAR 1:671 Section 6(11) requires new enrollment under the new ownership structure. Enrollment requirements can be found at http://www.chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm. If you are uncertain whether a change applies to the aforementioned regulation, please submit details of the change for advisement.*

1. **Individual Provider Name or Entity Name that this ADO pertains to:**

2. **List KY Medicaid provider number that this ADO pertains to:**

   KY Medicaid Provider Number:_____
   (One KY Medicaid provider number per form.)

3. **If you anticipate any change of ownership, management company or control within the year, state anticipated date of change and nature of the change.** ☐ *Check here for N/A*
   Date: **Change:**

4. **If you anticipate filing for bankruptcy within the year, enter anticipated date of filing. Date:** ☐ *Check here for N/A*

5. **If this facility is a subsidiary of a parent corporation, enter corporate FEIN #:** ☐ *Check here for N/A*
   Name:
   Address
   City: | State: | Zip

6. **List name, date of birth, SSN#/FEIN#, and address of each person or entity that owns 5% or more direct or indirect ownership or controlling interest in the applicant provider.** (Attach extra page if necessary.) **If you are enrolled as an individual, list *your* information.** *N/A Not Acceptable.*
   ☐ *Check here if no one owns 5% or more.*
   Name: | SSN:
   Business Address: | FEIN: | DOB:
   City: | State: | Zip:
   P.O. Box:
   City: | State | Zip:
   ****IF A CORPORATE ENTITY IS DISCLOSED IN QUESTION 6 ABOVE, THE BUSINESS LOCATIONS OF THE CORPORATE ENTITY MUST BE DISCLOSED. PLEASE ATTACH A SHEET TO DISCLOSE THIS INFORMATION.**

7. **List officers' and board members' information of disclosing entity. (Attach extra sheet if necessary listing same details below.)** ☐ *Check here for N/A*
   **The entire first name is required. Initials are not accepted.*
   Name(a): | Title:
   Address: | SSN:
   City: | State: | Zip:
   Name(b): | Title:
   Address: | SSN:
   City: | State: | Zip:

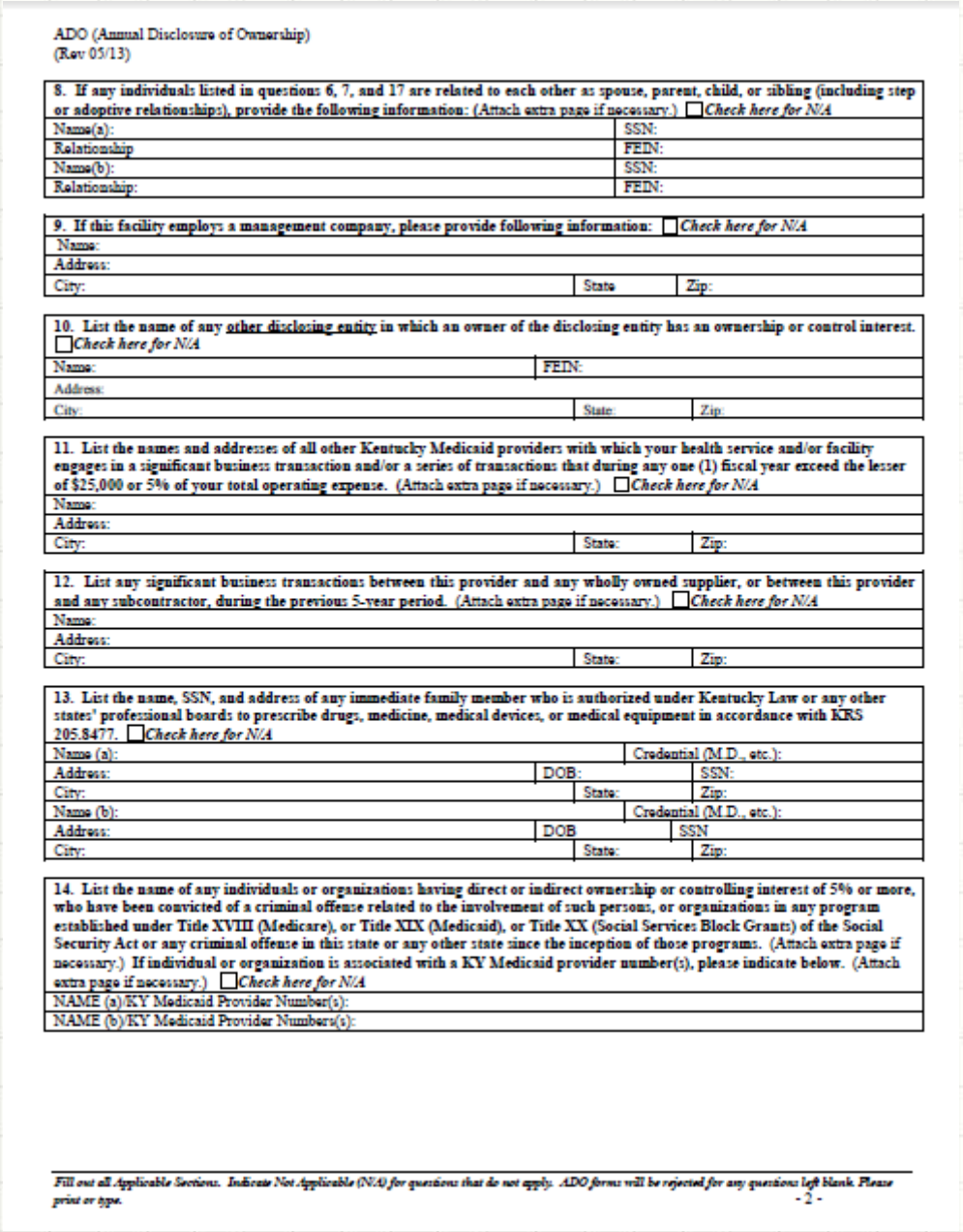
Fill out all Applicable Sections. Indicate Not Applicable (N/A) for questions that do not apply. ADO forms will be rejected for any questions left blank. Please print or type.

- 1 -

INDIVIDUAL

Common issues:

- Question 10
  - Answer if you are an owner in any other providers. Otherwise check N/A.
- Question 12
  - List any significant business transactions.
- Question 13
  - List any family members.
- Question 14
  - Be sure to include supporting documentation.



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(Rev 05/13)

8. If any individuals listed in questions 6, 7, and 17 are related to each other as spouse, parent, child, or sibling (including step or adoptive relationships), provide the following information: (Attach extra page if necessary.) ☐ *Check here for N/A*

Name(a):	SSN:
Relationship	FEIN:
Name(b):	SSN:
Relationship:	FEIN:

9. If this facility employs a management company, please provide following information: ☐ *Check here for N/A*

Name:		
Address:		
City:	State	Zip:

10. List the name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest. ☐ *Check here for N/A*

Name:	FEIN:	
Address:		
City:	State:	Zip:

11. List the names and addresses of all other Kentucky Medicaid providers with which your health service and/or facility engages in a significant business transaction and/or a series of transactions that during any one (1) fiscal year exceed the lesser of $25,000 or 5% of your total operating expense. (Attach extra page if necessary.) ☐ *Check here for N/A*

Name:		
Address:		
City:	State:	Zip:

12. List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year period. (Attach extra page if necessary.) ☐ *Check here for N/A*

Name:		
Address:		
City:	State:	Zip:

13. List the name, SSN, and address of any immediate family member who is authorized under Kentucky Law or any other states' professional boards to prescribe drugs, medicine, medical devices, or medical equipment in accordance with KRS 205.8477. ☐ *Check here for N/A*

Name (a):		Credential (M.D., etc.):
Address:	DOB:	SSN:
City:	State:	Zip:
Name (b):		Credential (M.D., etc.):
Address:	DOB	SSN
City:	State:	Zip:

14. List the name of any individuals or organizations having direct or indirect ownership or controlling interest of 5% or more, who have been convicted of a criminal offense related to the involvement of such persons, or organizations in any program established under Title XVIII (Medicare), or Title XIX (Medicaid), or Title XX (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs. (Attach extra page if necessary.) If individual or organization is associated with a KY Medicaid provider number(s), please indicate below. (Attach extra page if necessary.) ☐ *Check here for N/A*

NAME (a)/KY Medicaid Provider Number(s):
NAME (b)/KY Medicaid Provider Numbers(s):

Fill out all Applicable Sections. Indicate Not Applicable (N/A) for questions that do not apply. ADO forms will be rejected for any questions left blank. Please print or type.

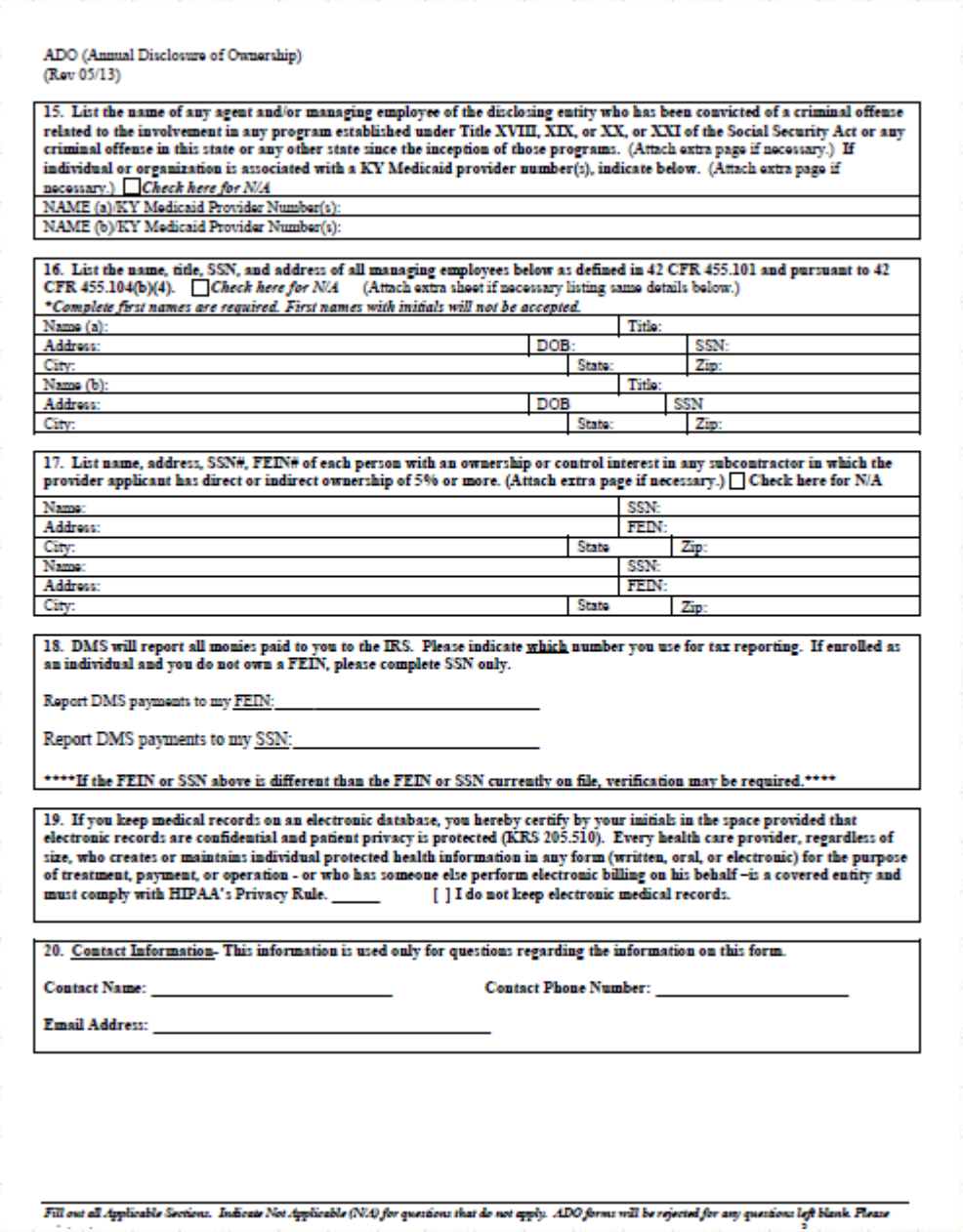
INDIVIDUAL

Common issues:

- Question 17
  - Ensure the question is completed.
  - Do not double answer. Either complete the information if it pertains to you as an individual provider or check the box for N/A.

- Question 18
  - Must be completed.
  - If you do not own 100% of a Federal Employer Identification Number (FEIN), you must complete the information with your individual Social Security Number only.
  - If you do own 100% of a Federal Employer Identification Number (FEIN), you must complete the information with your FEIN. For verification purposes, we must receive an IRS Verification. If you are unable to locate your IRS Verification you can contact the IRS at 800-829-0115 and request a "Letter 147C".

- Question 19
  - Do not double answer. Either list the individual providers initials on the line provided or check the box.



ADO (Annual Disclosure of Ownership)
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15. List the name of any agent and/or managing employee of the disclosing entity who has been convicted of a criminal offense related to the involvement in any program established under Title XVIII, XIX, or XX, or XXI of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs. (Attach extra page if necessary.) If individual or organization is associated with a KY Medicaid provider number(s), indicate below. (Attach extra page if necessary.) ☐ *Check here for N/A*

NAME (a)/KY Medicaid Provider Number(s):
NAME (b)/KY Medicaid Provider Number(s):

16. List the name, title, SSN, and address of all managing employees below as defined in 42 CFR 455.101 and pursuant to 42 CFR 455.104(b)(4). ☐ *Check here for N/A* (Attach extra sheet if necessary listing same details below.)
**Complete first names are required. First names with initials will not be accepted.*

Name (a):		Title:	
Address:	DOB:		SSN:
City:	State:		Zip:
Name (b):		Title:	
Address:	DOB		SSN
City:	State:		Zip:

17. List name, address, SSN#, FEIN# of each person with an ownership or control interest in any subcontractor in which the provider applicant has direct or indirect ownership of 5% or more. (Attach extra page if necessary.) ☐ Check here for N/A

Name:		SSN:
Address:		FEIN:
City:	State	Zip:
Name:		SSN:
Address:		FEIN:
City:	State	Zip:

18. DMS will report all monies paid to you to the IRS. Please indicate which number you use for tax reporting. If enrolled as an individual and you do not own a FEIN, please complete SSN only.

Report DMS payments to my FEIN: _____

Report DMS payments to my SSN: _____

****If the FEIN or SSN above is different than the FEIN or SSN currently on file, verification may be required.****

19. If you keep medical records on an electronic database, you hereby certify by your initials in the space provided that electronic records are confidential and patient privacy is protected (KRS 205.510). Every health care provider, regardless of size, who creates or maintains individual protected health information in any form (written, oral, or electronic) for the purpose of treatment, payment, or operation - or who has someone else perform electronic billing on his behalf –is a covered entity and must comply with HIPAA's Privacy Rule. _____ [ ] I do not keep electronic medical records.

20. Contact Information- This information is used only for questions regarding the information on this form.

Contact Name: _____ Contact Phone Number: _____

Email Address: _____

Fill out all Applicable Sections. Indicate Not Applicable (N/A) for questions that do not apply. ADO forms will be rejected for any questions left blank. Please

INDIVIDUAL

Common issues:

- Question 21
  - All fields must be completed.
  - The individual provider that the form pertains to must sign, date and title this field.

ADO (Annual Disclosure of Ownership)
(Rev 05/13)

21. I certify that all the information I have provided on this Department of Medicaid Services Annual Disclosure of Ownership form is accurate. Failure to provide accurate information could result in termination from the Medicaid program. I further acknowledge that changes in name, ownership, and address must be furnished within 35 days of change and that business transactions must be disclosed within 35 days of change or date of request by the Secretary or the Medicaid agency.

Enter original signature from the individual provider if this ADO form is for an individual provider. If this ADO is for an entity/group, an owner must sign. If the entity/group does not have an owner, an officer or board member (referenced in question 7) must sign.

Signature:_____ Date Signed:_____

Printed Name: _____

Title:_____

22. For Internal Use Only:

Department for Medicaid Services Signature: _____

Title: _____

Date: _____ ____ SAM ____ OIG/HHS

Fill out all Applicable Sections. Indicate Not Applicable (N/A) for questions that do not apply. ADO forms will be rejected for any questions left blank. Please print or type.

Group/Entity

GROUP/ENTITY

Same Form for Group/Entity and Individual

ADO (Annual Disclosure of Ownership)
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Annual Disclosure of Ownership (ADO) Instructions

Field #	Description
1	Enter name of individual or entity depending on who the ADO is in regards to.
2	Enter the KY Medicaid provider number.
3	Do you plan to have a change in ownership, management company or control within the next year? If so, when?
4	Do you anticipate filing bankruptcy? If so, when?
5	Enter the Federal Tax Identification Number (**if there is an affiliation with a chain**) along with name, address, city, state and zip code.
6	List name, address, SSN/FEIN of each person or organization having direct or indirect ownership or control interest in the disclosing entity. ***If no one owns 5% or more of provider, check box.*** If you are enrolled as an individual and do not own a FEIN, please enter your name and information. Corporate entities disclosed in this question must disclose every business location. ** IF A CORPORATE ENTITY IS DISCLOSED IN THIS QUESTION, THE BUSINESS LOCATIONS OF THE CORPORATE ENTITY MUST BE DISCLOSED. PLEASE ATTACH A SHEET TO DISCLOSE THIS INFORMATION.
Indirect Ownership Interest - means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. **Ownership interest** - means the possession of equity in the capital, the stock, or the profits of the disclosing entity. **Person with an ownership or control interest** - means a person or corporation that: • Has an ownership interest totaling 5% or more in a disclosing entity; • Has an indirect ownership interest equal to 5% or more in a disclosing entity; • Has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity; • Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or assets of the disclosing entity; • Is an officer or director of a disclosing entity that is organized as a corporation; or, • Is a partner in a disclosing entity that is organized as a partnership	
7	List officers' and board members' information of the disclosing entity. In the event, a sanction is returned for any names listed on this question, a SSN of the board member will be required.
8	If individuals disclosed in question 6, 7, and 17 are related, please list the relationship.
9	List name of management company. If not applicable, enter N/A. In the event, a sanction is returned for any names listed on this question, a FEIN will be required.
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Significant Business Transaction- means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of $25,000 or 5% of applicant's operating expense.	
12	List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year period. In the event, a sanction is returned for any names listed on this question, a SSN/FEIN will be required.
13	List name, SSN, address of any immediate family member who is authorized to prescribe drugs, medicine, devices or equipment.
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GROUP/ENTITY

15	List any agent and/or managing employee who has been convicted of a criminal offense related to any program established under Title XVIII, XIX or XX of the SSA or any criminal offense in this state or any other state. Indicate any KY Medicaid provider number(s) associated with individual or organization. In the event, a sanction is returned for any names listed on this question, a SSN/FEIN will be required.
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19	Enter your initials if you maintain electronic medical records and are HIPAA compliant. Check the box if you do not keep electronic medical records.
20	Please enter the contact information for DMS to contact should there be any questions regarding this form.
21	Signature: Enter original signature from the individual provider, owner, or officer/board member if the provider does not have an owner. If you are an individual provider, *your* signature is required. Printed Name: The individual signing this form must enter their printed name. Date: Enter the date this disclosure is signed. Title: Must be title of person signing this form. EXAMPLE: individual provider, owner, etc.
22	For Internal Purposes Only: DMS Authorized Signature

Please return form to:

KY Medicaid
P.O. Box 2110
Frankfort, KY 40602-2110

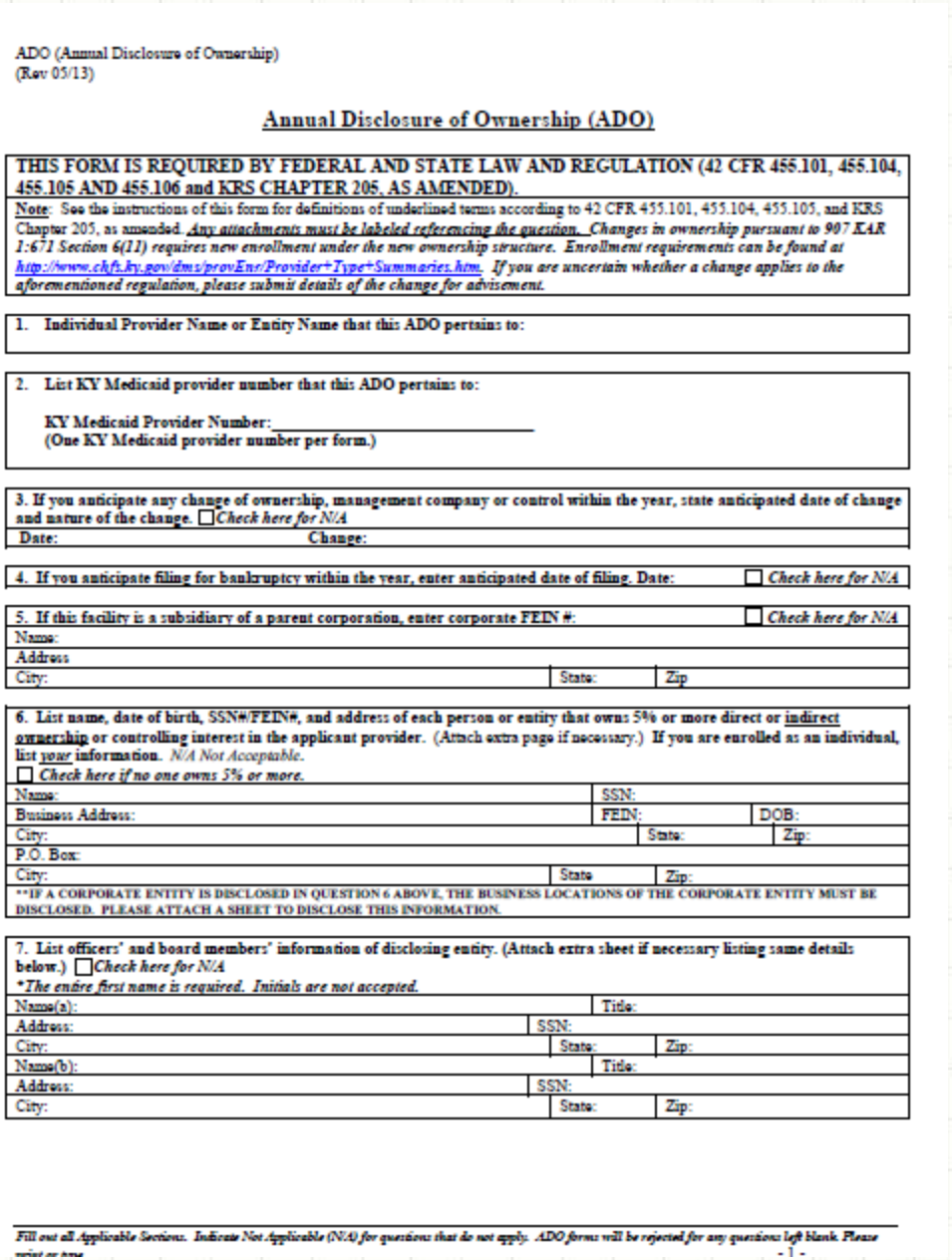
GROUP/ENTITY

ANSWER ALL QUESTIONS!

Check N/A if it does not apply but do not answer and check the box.

Common issues:

- Question 1
  - If applicable, list the **DBA name**.
- Question 2
  - Ensure the number listed is **the Medicaid provider number** and not the NPI, FEIN or taxonomy code.
- Question 5
  - Ensure the question is completed .
  - Do not double answer. Either complete the information or check the box for N/A.
- Question 6
  - Could be an entity.
  - Always list the entire legal name of an individual not just the first initial.
  - If an attachment is needed, make sure the **attachment** is **clearly labeled** for question 6 and the **question** indicates "**see attached**".
  - Do not double answer. Either complete the information or check the box for no one owns 5% or more.
- Question 7
  - If question 6 indicates the owner is an 'entity' or if the box is checked for no one owns 5% or more, this question (question 7) **must be completed.**
  - If an attachment is needed, make sure the **attachment** is **clearly labeled** for question 7 and the **question** indicates "**see attached**".
  - All individuals listed must have the entire first name (not just initials), title, address and SSN.
  - Do not double answer. Either complete the information or check the box for N/A.



ADO (Annual Disclosure of Ownership)
(Rev 05/13)

Annual Disclosure of Ownership (ADO)

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1. **Individual Provider Name or Entity Name that this ADO pertains to:**

2. **List KY Medicaid provider number that this ADO pertains to:**

   KY Medicaid Provider Number:_____
   (One KY Medicaid provider number per form.)

3. **If you anticipate any change of ownership, management company or control within the year, state anticipated date of change and nature of the change.** ☐ *Check here for N/A*
   Date: **Change:**

4. **If you anticipate filing for bankruptcy within the year, enter anticipated date of filing. Date:** ☐ *Check here for N/A*

5. **If this facility is a subsidiary of a parent corporation, enter corporate FEIN #:** ☐ *Check here for N/A*
   Name:
   Address
   City: | State: | Zip

6. **List name, date of birth, SSN#/FEIN#, and address of each person or entity that owns 5% or more direct or indirect ownership or controlling interest in the applicant provider.** (Attach extra page if necessary.) **If you are enrolled as an individual, list *your* information.** *N/A Not Acceptable.*
   ☐ *Check here if no one owns 5% or more.*
   Name: | SSN:
   Business Address: | FEIN: | DOB:
   City: | State: | Zip:
   P.O. Box:
   City: | State | Zip:
   ****IF A CORPORATE ENTITY IS DISCLOSED IN QUESTION 6 ABOVE, THE BUSINESS LOCATIONS OF THE CORPORATE ENTITY MUST BE DISCLOSED. PLEASE ATTACH A SHEET TO DISCLOSE THIS INFORMATION.**

7. **List officers' and board members' information of disclosing entity. (Attach extra sheet if necessary listing same details below.)** ☐ *Check here for N/A*
   **The entire first name is required. Initials are not accepted.*
   Name(a): | Title:
   Address: | SSN:
   City: | State: | Zip:
   Name(b): | Title:
   Address: | SSN:
   City: | State: | Zip:

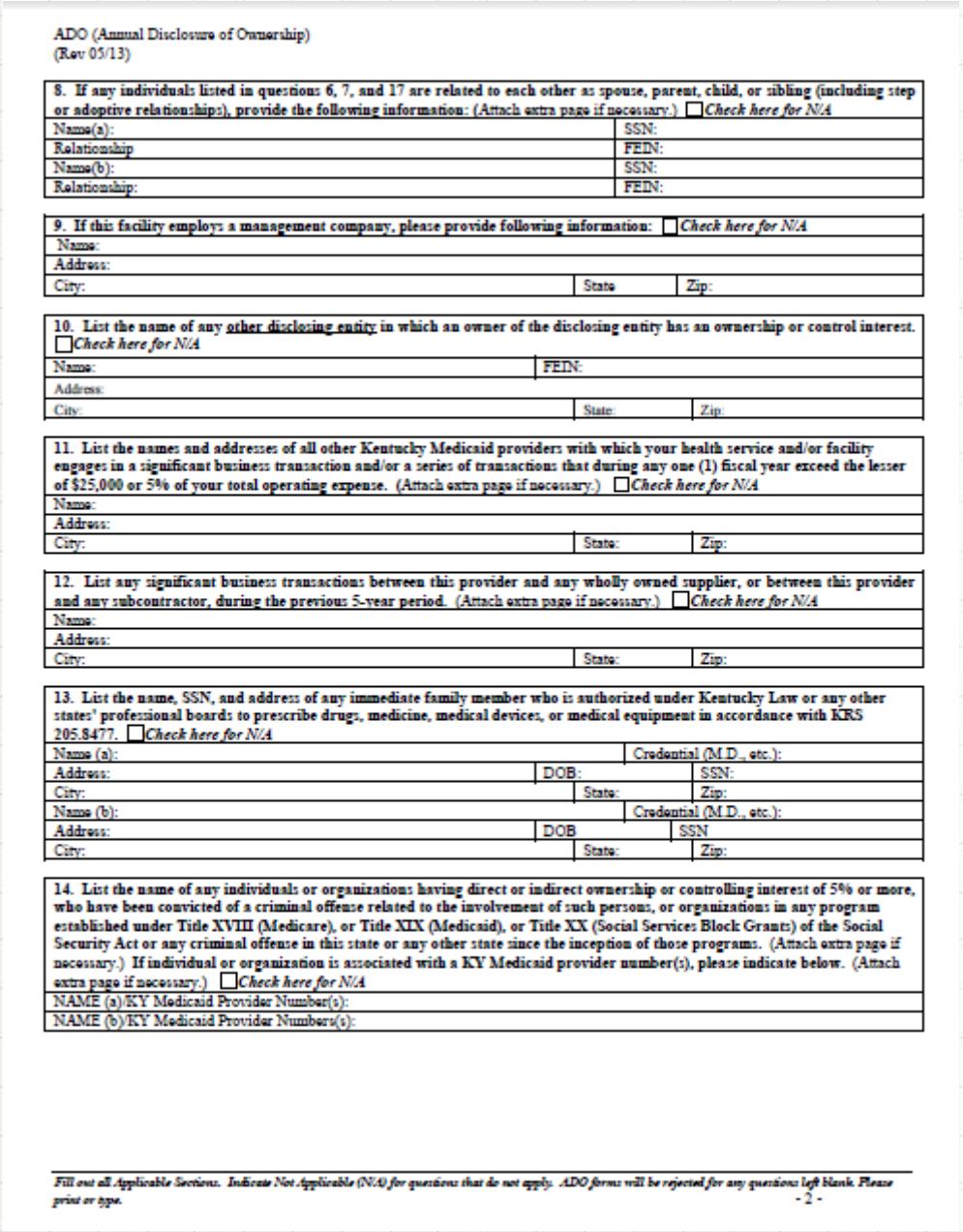
Fill out all Applicable Sections. Indicate Not Applicable (N/A) for questions that do not apply. ADO forms will be rejected for any questions left blank. Please print or type.

- 1 -

GROUP/ENTITY

Common issues:

- Question 8
  - **Entire first name** must be completed not just initials.
  - SSN is required.
- Question 10
  - Does owner in Question 6 have ownership of any other entities.
  - Do not double answer. Either complete the information or check the box for N/A.
- Question 14
  - Ensure the question is completed.
  - Attach documentation pertaining to the criminal offense.



ADO (Annual Disclosure of Ownership)
(Rev 05/13)

8. If any individuals listed in questions 6, 7, and 17 are related to each other as spouse, parent, child, or sibling (including step or adoptive relationships), provide the following information: (Attach extra page if necessary.) ☐ *Check here for N/A*

Name(a):	SSN:
Relationship	FEIN:
Name(b):	SSN:
Relationship:	FEIN:

9. If this facility employs a management company, please provide following information: ☐ *Check here for N/A*

Name:		
Address:		
City:	State	Zip:

10. List the name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest. ☐ *Check here for N/A*

Name:	FEIN:	
Address:		
City:	State:	Zip:

11. List the names and addresses of all other Kentucky Medicaid providers with which your health service and/or facility engages in a significant business transaction and/or a series of transactions that during any one (1) fiscal year exceed the lesser of $25,000 or 5% of your total operating expense. (Attach extra page if necessary.) ☐ *Check here for N/A*

Name:		
Address:		
City:	State:	Zip:

12. List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year period. (Attach extra page if necessary.) ☐ *Check here for N/A*

Name:		
Address:		
City:	State:	Zip:

13. List the name, SSN, and address of any immediate family member who is authorized under Kentucky Law or any other states' professional boards to prescribe drugs, medicine, medical devices, or medical equipment in accordance with KRS 205.8477. ☐ *Check here for N/A*

Name (a):		Credential (M.D., etc.):
Address:	DOB:	SSN:
City:	State:	Zip:
Name (b):		Credential (M.D., etc.):
Address:	DOB	SSN
City:	State:	Zip:

14. List the name of any individuals or organizations having direct or indirect ownership or controlling interest of 5% or more, who have been convicted of a criminal offense related to the involvement of such persons, or organizations in any program established under Title XVIII (Medicare), or Title XIX (Medicaid), or Title XX (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs. (Attach extra page if necessary.) If individual or organization is associated with a KY Medicaid provider number(s), please indicate below. (Attach extra page if necessary.) ☐ *Check here for N/A*

NAME (a)/KY Medicaid Provider Number(s):
NAME (b)/KY Medicaid Provider Numbers(s):

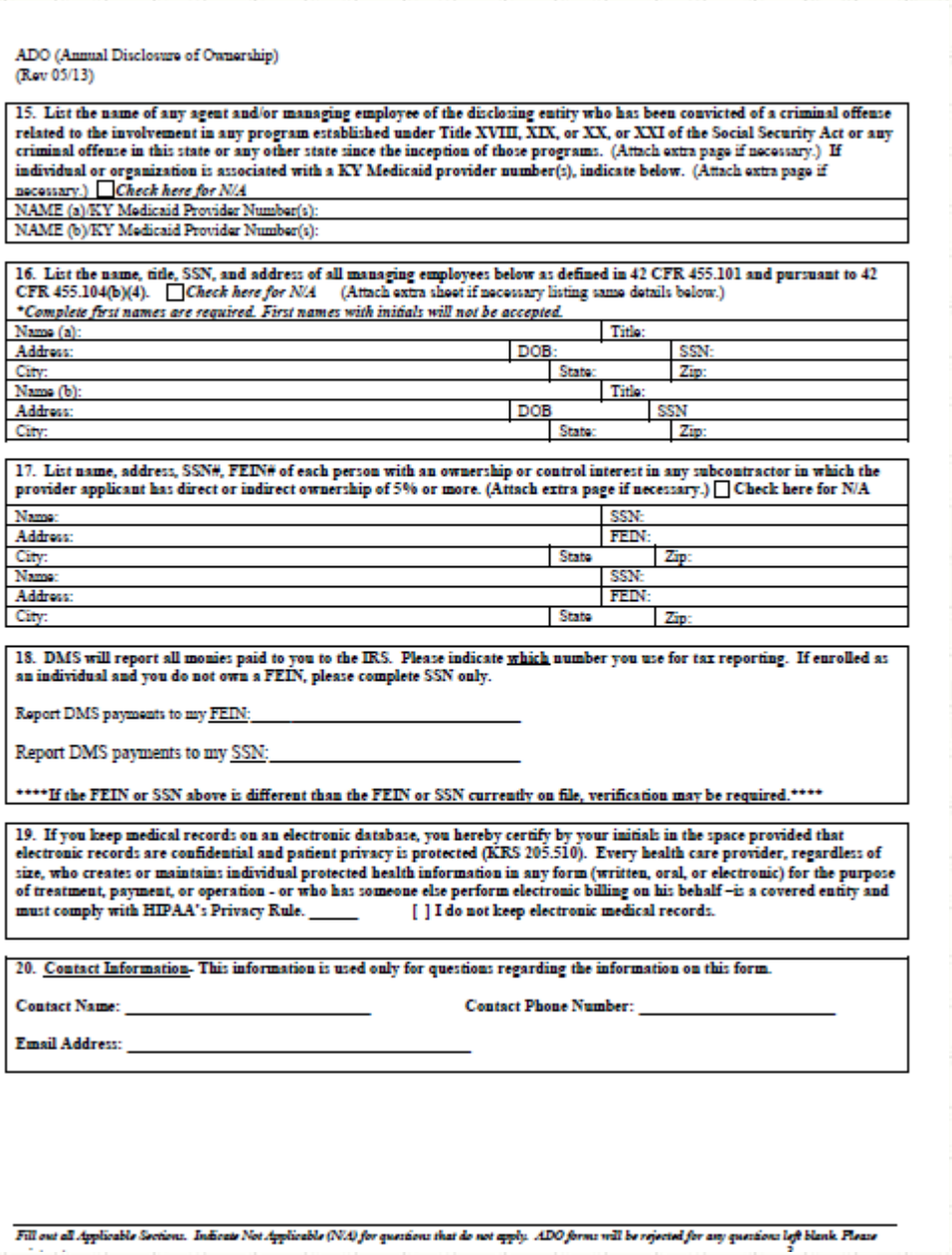
Fill out all Applicable Sections. Indicate Not Applicable (N/A) for questions that do not apply. ADO forms will be rejected for any questions left blank. Please print or type.

- 2 -

GROUP/ENTITY

Common issues:

- Question 15
  - Ensure the question is completed.
  - Additional information may be needed.
- Question 16
  - Entire first name must be completed not just initials along with the title, address, DOB and SSN.
  - If an attachment is needed, make sure the **attachment** is **clearly labeled** for question 16 and the **question** indicates "**see attached**".
- Question 17
  - If your response is anything other than N/A make sure the information is in regards to '**subcontractors**'.
  - Ensure the question is completed.
- Question 18
  - Must be completed.
  - For verification purposes we must receive an IRS Verification. If you are unable to locate your IRS Verification you can contact the IRS at 800-829-0115 and request a "Letter 147C".
- Question 19
  - Do not double answer. Either list the initials on the line provided or check the box.



ADO (Annual Disclosure of Ownership)
(Rev 05/13)

15. List the name of any agent and/or managing employee of the disclosing entity who has been convicted of a criminal offense related to the involvement in any program established under Title XVIII, XIX, or XX, or XXI of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs. (Attach extra page if necessary.) If individual or organization is associated with a KY Medicaid provider number(s), indicate below. (Attach extra page if necessary.) ☐ *Check here for N/A*

NAME (a)/KY Medicaid Provider Number(s):
NAME (b)/KY Medicaid Provider Number(s):

16. List the name, title, SSN, and address of all managing employees below as defined in 42 CFR 455.101 and pursuant to 42 CFR 455.104(b)(4). ☐ *Check here for N/A* (Attach extra sheet if necessary listing same details below.)
**Complete first names are required. First names with initials will not be accepted.*

Name (a):		Title:	
Address:	DOB:		SSN:
City:	State:		Zip:
Name (b):		Title:	
Address:	DOB		SSN
City:	State:		Zip:

17. List name, address, SSN#, FEIN# of each person with an ownership or control interest in any subcontractor in which the provider applicant has direct or indirect ownership of 5% or more. (Attach extra page if necessary.) ☐ Check here for N/A

Name:		SSN:	
Address:		FEIN:	
City:	State		Zip:
Name:		SSN:	
Address:		FEIN:	
City:	State		Zip:

18. DMS will report all monies paid to you to the IRS. Please indicate which number you use for tax reporting. If enrolled as an individual and you do not own a FEIN, please complete SSN only.

Report DMS payments to my FEIN: _____

Report DMS payments to my SSN: _____

****If the FEIN or SSN above is different than the FEIN or SSN currently on file, verification may be required.****

19. If you keep medical records on an electronic database, you hereby certify by your initials in the space provided that electronic records are confidential and patient privacy is protected (KRS 205.510). Every health care provider, regardless of size, who creates or maintains individual protected health information in any form (written, oral, or electronic) for the purpose of treatment, payment, or operation - or who has someone else perform electronic billing on his behalf –is a covered entity and must comply with HIPAA's Privacy Rule. _____ [ ] I do not keep electronic medical records.

20. Contact Information- This information is used only for questions regarding the information on this form.

Contact Name: _____ Contact Phone Number: _____

Email Address: _____

Fill out all Applicable Sections. Indicate Not Applicable (N/A) for questions that do not apply. ADO forms will be rejected for any questions left blank. Please

GROUP/ENTITY

Common Issues:

- Question 21
  - All fields must be completed.
  - Signature of the ADO:
    - If there is an individual owner, they must sign the ADO.
    - If no one owns 5% or more or is owned by an entity, an officer/board member must sign the form. The officer/board member must be listed on question 7.

ADO (Annual Disclosure of Ownership)
(Rev 05/13)

21. I certify that all the information I have provided on this Department of Medicaid Services Annual Disclosure of Ownership form is accurate. Failure to provide accurate information could result in termination from the Medicaid program. I further acknowledge that changes in name, ownership, and address must be furnished within 35 days of change and that business transactions must be disclosed within 35 days of change or date of request by the Secretary or the Medicaid agency.

Enter original signature from the individual provider if this ADO form is for an individual provider. If this ADO is for an entity/group, an owner must sign. If the entity/group does not have an owner, an officer or board member (referenced in question 7) must sign.

Signature:_____ Date Signed:_____

Printed Name: _____

Title:_____

22. For Internal Use Only:

Department for Medicaid Services Signature: _____

Title: _____

Date: _____ ____ SAM ____ OIG/HHS

Fill out all Applicable Sections. Indicate Not Applicable (N/A) for questions that do not apply. ADO forms will be rejected for any questions left blank. Please print or type.

Change in Ownership??

A current copy of the regulations are included in this slideshow for your reference.

If a change in ownership **has** occurred per 907 KAR 1:671 Section 6(11)

- Must be reported within 35 days.
- Provider must re-enroll under the new ownership (Map811 Non-Credentialed Application)

If a change in ownership **has not** occurred per 907 KAR 1:671 Section 6(11)

- An ownership discrepancy statement must be submitted along with the ADO explaining:
  - What the changes are
  - When the changes occurred
- Ownership discrepancy statement must be signed by an individual owner. If there is no individual owner, an officer or board member (referenced on question #7) must sign the statement.

Most Common Changes Reported

- Divorce/Marriage
- Death
- Retirement
- Stockholder changes
- Individual sells ownership to another individual

CHOW depends on what type of business entity is involved

Does the change require a new application and new provider number or does it only require an ADO and a disclosure statement about what change occurred and when?

Is it a change of ownership?

- Provider is a Corporation
  - It is **NOT** a change in ownership if there is a change in stockholders, board of directors, board of trustees, officers, or members.
    - Disclosure of change still required on an ADO with a detailed statement describing the change and when it occurred.
  - It **IS** a change in ownership if the corporation merges and original provider corporation ceases to exist
    - New application is required.
    - New provider number will be issued.

NOTE: We are not providing legal advice. Information is based on the CMS State Operations Manual. Determinations are very case and fact specific. Be sure to evaluate your circumstances independent of this information and seek private legal advice.

Is it a change of ownership?

- Provider is a Partnership
  - Removal, addition or substitution of an individual partner **IS** a change of ownership
    - New application is required.
    - New provider number will be issued.
- Provider is a Sole Proprietorship
  - **Any** change **IS** a change in ownership even if original owner is part of the new ownership.
    - New application is required.
    - New provider number will be issued.

NOTE: We are not providing legal advice. Information is based on the CMS State Operations Manual. Determinations are very case and fact specific. Be sure to evaluate your circumstances independent of this information and seek private legal advice.

Supporting Documentation (if applicable)

In an effort to ensure the KY Medicaid Provider file is up to date, additional documentation may be required in an effort to prevent the provider from end-dating (terminating) from the KY Medicaid Program.

License

If a current license has not been received, it will be required before ADO can be processed.

Hint: The address on the license must match the provider name and address we have on file. If there is a discrepancy, more documentation will be required.

CLIA

If a current CLIA has not been received, it will be required before ADO can be processed.

Hint: The address on the CLIA must match the provider name and address we have on file. If there is a discrepancy, more documentation will be required.

JCAHO

If a current JCAHO has not been received, it will be required before ADO can be processed.

Hint: The address on the JCAHO must match the provider name and address we have on file. If there is a discrepancy, more documentation will be required.

DME Accreditation

If a current DME Accreditation has not been received, it will be required before ADO can be processed.

Hint: The address on the DME Accreditation must match the provider name and address we have on file. If there is a discrepancy, more documentation will be required.

Hint: If the provider is exempt from DME Accreditation, we must have a signed statement attesting to the exemption. The statement must be signed by the owner. If no one owns 5% or more or if owned by an entity, an officer/board member must sign.

HME License

If a current HME License has not been received, it will be required before ADO can be processed.

Hint: The address on the HME License must match the provider name and address we have on file. If there is a discrepancy, more documentation will be required.

Hint: If the provider is exempt from the HME License, we must have a signed statement attesting to the exemption. The statement must be signed by the owner. If no one owns 5% or more or if owned by an entity, an officer/board member must sign.

DHS/INS Documentation

Any individual applicant who has provided a social security card that states "valid for work only with DHS/INS Authorization" must include additional supporting documentation. Supporting documentation will depend on the reason for the restriction. Additional supporting documents shall include one of the following:

- DS-2019
- I-129
- I-20
- Work Authorization Card
- Permanent Resident Card

IRS Verification

If you are unable to locate the IRS Verification you can contact the IRS at 800-829-0115 or 800-829-4933 and request a "Letter 147C"

The W-9 is no longer accepted as verification of the FEIN

Sanction Verification

Once the ADO is considered complete, a sanction check will be performed. If any "hits" are found, more documentation or information may be required.

Electronic ADO Submission

- This new initiative will allow providers to submit their Annual Disclosure of Ownership (ADO) electronically via KYHealthNet. Providers accessing KYHealthNet will no longer have to complete and mail paper forms to DMS for processing.

- KYHealthNet is a portal that allows providers to access certain information related to Kentucky Medicaid. **All providers should register to use KYHealthNet in order to submit an electronic ADO and also to access items that may be automated in the future.**

- To register your provider account, you will need to contact the HP EDI Helpdesk at 1-800-205-4696 or KY_EDI_Helpdesk@hp.com for assistance.

RESOURCES

- Please mail ADO to:

KY Medicaid
PO Box 2110
Frankfort, KY 40602

- Provider Licensing Representatives:

(877) 838-5085
8:00am – 4:30pm
(closed Noon to 1:00 p.m.)

Regulations

The regulations listed on the next pages are listed for you convenience.

Please note these regulations can be modified at any time. To ensure you are reviewing the most accurate information, the website is listed for your reference.

907 KAR 1:671

http://www.lrc.ky.gov/kar/907/001/671.htm

907 KAR 1:671. Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions.

RELATES TO: KRS Chapter 13B, 194.515, 205.510-205.990, 312.015, Chapter 360, 42 C.F.R. 431.107, 431.151-431.154, 447.10, 455, 1002, 1003, 42 U.S.C. 1128a-b(13), 1320a-3, a-3a, a-5, a-7, 1395cc, vv, 1396b, d, m, n, 2000d

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560, 205.6318, 205.8467, 42 C.F.R. 1002.1-.230, 1003.105, 42 U.S.C. 1320a-7, 1396a, b(q), d(d), m, r(a), EO 2004-726

NECESSITY, FUNCTION, AND CONFORMITY: EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services. The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.8451 through 205.990, 205.624 and 194A.515 provide that the Cabinet for Health Services and the Department for Medicaid Services shall be responsible for the control of Medicaid provider fraud and abuse. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the provisions relating to Medicaid provider participation, withholding overpayments, appeal process and sanctions.

Section 1. Definitions. (1) "Abuse" means provider abuse or recipient abuse as defined by KRS 205.8451(8) and (10).

(2) "Active provider number" means the provider billing number issued by the department, or its fiscal agent, to a provider that has presented to the department, or its fiscal agent, a Medicaid claim for a supply or covered service for payment under that number during the period of the previous twelve (12) consecutive months.

(3) "Adequate access" means pursuant to 42 CFR 1396a(8) all individuals wishing to make application for medical assistance under the Medicaid Program shall have an opportunity to do so, and that assistance shall be furnished with reasonable promptness to all eligible individuals.

(4) "Administrative appeal process" means an initial written request for redress setting forth the issues in dispute, dispute resolution meeting, review of documentation, prehearing, administrative hearing, recommended order, final order and all deliberations or exchange of documents or information between a provider and the department in accordance with KRS Chapter 13B.

(5) "Affiliate" means an individual agency or organization controlled by a provider or associated with a provider under common ownership or control.

(6) "Applicant" means an individual, agency, entity, or organization that submits an application to become a Medicaid provider.

(7) "Application" means the completion and submission of a Medicaid provider agreement and all required addendum and documentation specific to a provider type, which is the contract between the provider and the department for the provision of Medicaid services.

(8) "Billing agent" means an individual, agency, entity or organization that is authorized by a provider to prepare and submit claims on behalf of a provider to the department, or its fiscal agent.

(9) "Bribes and kickbacks" means soliciting or receiving payment, or offering or making payment whether in cash or goods or services, in return for:

(a) Referring a recipient to a provider for medical care, services or supplies; or

(b) Purchasing, leasing, ordering or recommending medical care, services or supplies, for which payment is claimed under the Medicaid Program.

(10) "Cabinet" means the Cabinet for Health and Family Services.

(11) "Claim" means a manually-created paper, or a computer-based electronically-created and transmitted request for payment under the Medicaid Program that relates to each individual billing submitted by a provider, or their billing agent, to the department which details services rendered to a recipient on a specific date. A claim may be either a line item of service or multiple services for one (1) recipient on a bill.

(12) "Conversion" means converting a Medicaid payment, or a part of a payment, to a use or benefit other than for the use and benefit intended by the Medicaid Program.

(13) "Convicted" means as defined in KRS 205.8475.

(14) "Demand letter" means correspondence to an active or inactive provider stating a dollar amount is owed the program and shall be paid by a given date.

(15) "Department" means the Department for Medicaid Services and its designated agents.

(16) "Disclosing entity" means a Medicaid provider or the fiscal agent for the department.

(17) "Disclosure" means the provision of information in accordance with the requirements established in 42 CFR 455, Subpart B.

(18) "Exclusion" means the termination of the participation of a provider or the denial of the enrollment of a provider.

(19) "Factor" means as defined in 42 CFR 447.10.

(20) "False claim" means a claim for:

(a) Unfurnished medical care, services, or supplies; or

(b) Medical care, services, or supplies provided:

1. In excess of accepted standards of practice for the medical care or other type of service;

2. In excess of established limits which were communicated, in writing, to providers by the department; or

3. If there is documentation that the provider has knowledge of third-party coverage of the recipient, but the provider knowingly chooses not to bill the third-party payer.

(21) "Fiscal agent" means a contractor that processes or pays provider claims on behalf of the department.

(22) "Full investigation" means the activities of Kentucky's Medicaid Fraud and Abuse Control Unit of the Office of the Attorney General (MFACU) or other law enforcement or investigative agency having authority to resolve a complaint of Medicaid fraud or abuse.

(23) "Furnish" means to provide medical care, services, or supplies that are:

(a) Provided directly by a provider;

(b) Provided under the supervision of a provider; or

(c) Prescribed by a provider.

(24) "Inactive provider number" means the provider billing number issued by the department, or its fiscal agent, to a provider that failed to present a Medicaid claim for medical care, services, or supplies for payment under that number to the department, or its fiscal agent, during the period of the previous twelve (12) consecutive months;

(25) "Interest" means the prime interest rate that is:

(a) Charged as a simple interest by banks rounded to the nearest full percent, as quoted by commercial banks to large business, as determined by the board of governors of the Federal Reserve System; and

(b) In effect on the close of business, July 1, which is the first day of the state fiscal year.

(26) "Knowingly" means as defined in KRS 205.8451(5).

(27) "Managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who conducts the day-to-day operation of, an institution, entity, organization, or agency.

(28) "Material omission" means a failure by a provider to report or advise the department of any fact, that if known to the department, would have caused the department to deny, reduce, or otherwise withhold any portion of reimbursement for a billed covered service.

(29) "Medicaid Fraud and Abuse Control Unit" or "MFACU" means a unit in the Office of the Attorney General of Kentucky, certified under the provisions of 42 U.S.C. 1396b(q), that conducts a statewide program for the investigation and prosecution of violations of state laws regarding fraud and abuse in connection with the Medicaid Program.

(30) "Preliminary investigation" means the activities of the Office of Inspector General (OIG), MFACU, or the department to determine whether a complaint of Medicaid fraud or abuse has sufficient basis to warrant a full investigation.

(31) "Program" means the state Medicaid Program as defined by 42 U.S.C. 1396a.

(32) "Provider" means as defined by KRS 205.8451(7).

(33) "Recipient" means as defined by KRS 205.8451(9).

(34) "Reliable evidence" means:

(a) A preliminary determination based upon a preponderance of evidence as verified by the department by audit, of unacceptable practices or significant overpayments;

(b) Information of an ongoing investigation of a provider based on a preponderance of evidence, as verified by the department, involving fraud or criminal conduct pertaining to the Medicaid Program;

(c) Information based on a preponderance of evidence, as verified by the department, from a state professional medical licensing or certifying agency of an ongoing investigation of a Medicaid provider involving fraud, abuse, professional misconduct, unprofessional conduct, or utilization; or

(d) Information from the department or other sources based on a preponderance of evidence regarding unacceptable practices, relevant past criminal activities or program abuse.

(35) "Sanction" means an administrative action taken by the department which limits or bars an individual's, agency's, entity's, or organization's participation in the Medicaid Program or imposes a fiscal penalty against the provider, including the imposition of civil penalties, or interest imposed at the department's discretion, or the withholding of future payments.

(36) "Service" or "services" means a supply, covered care or covered service under the Medicaid Program.

(37) "Subcontractor" means an individual, agency, entity, or organization to which a disclosing entity has:

(a) Contracted or delegated some of its management functions or responsibilities of providing medical care or services to its patients; or

(b) Entered into a contract, agreement, purchase order or lease including real property, to obtain space, supplies, equipment or nonmedical services associated with providing services and supplies that are covered under the Medicaid Program.

(38) "Supplier" means an individual, agency, entity, or organization from which a provider purchases goods or services used in carrying out its responsibilities under the Medicaid Program.

(39) "Terminated" means a provider's participation in the Medicaid Program has been ended, and that a contractual relationship no longer exists between a provider and the department for the provision of Medicaid covered services to Medicaid eligible recipients by that individual, agency, entity, organization, fiscal agents or subcontractors of the provider.

(40) "Unacceptable practice" means conduct by a provider which constitutes "fraud" or "provider abuse", as defined in KRS 205.8451(2) or (8), or willful misrepresentation, and includes the following practices:

(a) Knowingly submitting, or causing the submission of false claims, or inducing, or seeking to induce, a person to submit false claims;

(b) Knowingly making, or causing to be made, or inducing, or seeking to induce, a false, fictitious or fraudulent statement or misrepresentation of material fact in claiming a Medicaid payment, or for use in determining the right to payment;

(c) Having knowledge of an event that affects the right of a provider to receive payment and concealing or failing to disclose the event or other material omission with the intention that a payment be made or the payment is made in a greater amount than otherwise owed;

(d) Conversion;

(e) Soliciting or accepting bribes or kickbacks;

(f) Failing to maintain or to make available, for purposes of audit or investigation, administrative and medical records necessary to fully disclose the medical necessity for the nature and extent of the medical care, services and supplies furnished, or to comply with other requirements established in 907 KAR 1:673, Section 2;

(g) Knowingly submitting a claim or accepting payment for medical care, services, or supplies furnished by a provider who has been terminated or excluded from the program;

(h) Seeking or accepting additional payments, for example, gifts, money, donations, or other consideration, in addition to the amount paid or payable under the Medicaid Program for covered medical care, services, or supplies for which a claim is made;

(i) Charging or agreeing to charge or collect a fee from a recipient for covered services which is in addition to amounts paid by the Medicaid Program, except for required copayments or recipient liability, if any, required by the Medicaid Program;

(j) Engaging in conspiracy, complicity, or criminal syndication;

(k) Furnishing medical care, services, or supplies that fail to meet professionally recognized standards, or which are found to be noncompliant with licensure standards promulgated under KRS Chapter 216B and failing to correct the deficiencies or violation as reported to the department by the Office of Inspector General, for health care or which are beyond the scope of the provider's professional qualifications or licensure;

(l) Discriminating in the furnishing of medical care, services, or supplies as prohibited by 42 U.S.C. 2000d;

(m) Having payments made to or through a factor, either directly or by power of attorney, as prohibited by 42 CFR 447.10;

(n) Offering or providing a premium or inducement to a recipient in return for the recipient's patronage of the provider or other provider to receive medical care, services or supplies under the Medicaid Program;

(o) Knowingly failing to meet disclosure requirements;

(p) Unbundling as defined under subsection (40) of this section; or

(q) An act committed by a nonprovider on behalf of a provider which, if committed by a provider, would result in the termination of the provider's enrollment in the program.

(41) "Unbundling" means submitting fragmented or multiple bills that results in a higher total reimbursement for tests and services that were performed within a specified time period that are required to be billed under a single bill code pursuant to 42 U.S.C. 1396b, that mandates a provider utilize the uniform identification coding system Current Procedural Terminology ("CPT") that establishes the specific range of services that are to be billed as one (1) CPT code.

(42) "Withholding" means not paying a provider for claims which have been processed, pending the results of an investigation of a report of fraud or willful misrepresentation based upon receipt of reliable evidence or as a result of provider bankruptcy, failure to submit timely cost reports, or closure or termination of a business.

Section 2. Methods for Recoupment of Overpayments. (1) If a determination is made by the department that a provider was overpaid, a demand letter shall be sent to the provider, at his last known mailing address. If a provider billed through an agent or entity, a copy of a demand letter may be mailed to a provider's designated payment last known mailing address. The demand letter shall contain:

(a) The amount of the overpayment;

(b) The period of time involved;

(c) The basis for determining the overpayment exists;

(d) Language granting a provider sixty (60) days advance notice that the repayment is due in full; and

(e) Appeal rights, if any.

(2) Departmental adjustments of the reimbursements rates, and differences between estimated and actual costs a provider incurred in determining reimbursements, may create situations where a provider was overpaid. The letter of notification of adjustments and the monies due under this subsection shall include:

(a) All required elements of subsection (1) of this section;

(b) Documentation to support the department's determination of adjustments; and

(c) Appeal rights, if any.

(3) The provider shall within:

(a) Sixty (60) calendar days from the date of the demand letter, pay the amount of overpayment in full; or

(b) Sixty (60) calendar days from the date of the demand letter, or during the administrative appeal process, submit a written request for a payment plan.

(4) If the amount of overpayment resulted from rate revisions and subsequent recalculations within the Medicaid Management Information System, the department shall apply a rate adjustment against the next payment cycle for the provider prior to notifying the provider in writing of the amount of the overpayment.

(5) A payment plan may be approved by the department, if a provider documents that payment in full would create an undue hardship. A written declaration of undue hardship shall include the following:

(a) Copies of financial statements which indicate payment in full within sixty (60) calendar days would create an undue hardship; and

(b) Copies of notarized letters from at least two (2) financial institutions indicating the provider's loan request was denied for the overpayment amount.

(6) Except as provided for in subsection (7) of this section, payment plans shall not extend beyond a six (6) month period.

(7) A payment plan approved, in writing, by the Commissioner of the Department for Medicaid Services, in accordance with subsection (5) of this section, may be approved in excess of six (6) months, if the monthly repayment exceeds twenty-five (25) percent of the provider's average monthly Medicaid payment based upon the payments made the previous twelve (12) months.

(8) A payment plan approved in excess of six (6) months shall include provisions for payments of both principal and interest as provided in KRS Chapter 360.

(9) If a provider fails to make a payment as specified in the payment plan or takes no action toward repayment, the department shall recoup the amount due from future payments. If a provider has insufficient funds available for recoupment through the payment system in the first payment cycle following the due date, or no longer participates in the Medicaid Program, payments shall continue to be recouped and the department may take all lawful actions to collect the debt.

(10) Disputes.

(a) If a provider disputes the amount of overpayment, a provider may initiate the administrative appeals process in accordance with Section 8 or 9 of this administrative regulation.

(b) A timely-filed request of administrative appeal process shall stay the recoupment activities by the department pertaining to the issues on appeal until the administrative appeal process is final.

(c) If the department, after reviewing all documentation submitted during the administrative appeal process, determines that no adjustments are required, the initial determination shall stand.

(d) If the department determines that the amount of overpayment demand should be reduced, a refund due to the provider shall be refunded to him within thirty (30) calendar days from the date of the determination.

(e) If it is determined that the amount requested should be increased, a provider shall be notified by a new demand letter pursuant to subsection (1) of this section.

(11) Withholding Medicare payments to recover Medicaid overpayments.

(a) The department may request that the Centers for Medicare and Medicaid Services (CMS) withhold future Medicare payments to a provider in order to recover Medicaid overpayments to that provider, pursuant to 42 U.S.C. 1395vv.

(b) Amounts withheld and forwarded to the department by CMS which are ultimately determined by the department to be in excess of overpayments due to the Medicaid Program shall be returned to the provider.

(12) Statutory recovery. The department shall not issue payments otherwise due to a provider, if the department has been notified by a state or federal government agency or by a court that a court order exists requiring the department to withhold payments. The payments shall be withheld in accordance with the provisions of the order.

(13) Medicare overpayments. If ordered to recoup payment by CMS, the department shall recoup the federal share of Medicaid payments, which is the portion of the payment funded with federal funds, as a means to recover Medicare overpayments pursuant to 42 U.S.C. 1396m.

(14) A contract for the sale or change of ownership of a provider participating in the Medicaid Program shall specify whether the buyer or seller is responsible for amounts owed to the department by the provider, regardless of whether the amounts have been identified at the time of the sale. In the absence of specification in the contract for the sale or change of ownership, the recipient of the payment, who otherwise would be the provider of record at the time the department made the erroneous payment, shall have the responsibility for liabilities arising from that payment, regardless of when identified.

Section 3. Administrative Process for Identification and Referral of Unacceptable Practices. (1) A preliminary investigation of alleged unacceptable practice shall be conducted by the department or its agent, if:

(a) A complaint is received by or referred from:

1. The department;
2. The cabinet; or
3. The Office of Attorney General; or

(b) Questionable or unacceptable practices are identified by the department.

(2) If the findings of a preliminary investigation indicate that an incident of fraud or abuse involving substantial allegations or other indication of fraud may have occurred under the Medicaid Program, a referral for a full investigation shall be made to the MFACU or the Office of the United States Attorney, if appropriate.

(3) In order to facilitate a full investigation, the department shall, at the request of the MFACU or the Office of the United States Attorney, provide access to, and free copies of, records, data, or information kept by the department, its contractors, or providers, if authorized, as specified in 907 KAR 1:672, Section 4.

(4) A full investigation shall continue until:

(a) Appropriate legal action is initiated;

(b) The investigation is discontinued because of insufficient evidence to support the allegation of unacceptable practice; or

(c) The case is returned to the department for administrative action.

(5) During a preliminary or full investigation, the department may make an administrative determination that a provider has committed an act of unacceptable practice based on receipt of reliable evidence. The department shall issue a written notice of a determination of unacceptable practice to a provider upon which an exclusion or sanction is intended to be imposed, as specified in Section 5 of this administrative regulation. The notice shall be mailed to a provider's last know mailing address. A copy may be mailed to the provider's designated payment last known mailing address. The notice shall clearly state:

(a) The determination made;

(b) The basis and specific reasons for the determination;

(c) The effect of the action to be taken;

(d) The amount of overpayment or penalty, if any;

(e) The effective date of the action; and

(f) The administrative appeal process rights of the provider, if any, as established in Sections 8 and 9 of this administrative regulation.

(6) During a preliminary or full investigation, the department may refer the case to the MFACU or the Office of the United States Attorney for appropriate action.

(7) The Medicaid Program or its fiscal agents or contractors may, as it deems necessary and reasonable, use random or other statistical sampling methodologies and extrapolate the Medicaid Program's findings based on the sample.

Section 4. Withholding of Payments During an Investigation of Fraud or Willful Misrepresentation. (1) The department may withhold Medicaid payments pursuant to 42 CFR 455.23 upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud or willful misrepresentation under the Medicaid Program.

(2) The department may withhold payments without first notifying a provider of its intention to withhold payments.

(3) The department shall mail written notice to a provider at the provider's last known mailing address of its withholding of program payments within five (5) calendar days of the date upon which withholding began. The department may mail a copy of the written notice to an agent or entity that submitted the bills, which resulted in the amounts to be withheld pursuant to 42 CFR 455.23.

(a) The notice shall establish the general allegations of the nature of the withholding action, including the types of payments and payment code sections to which fraud or willful misrepresentation is alleged to have occurred. The notice shall not disclose specific information concerning its ongoing investigation.

(b) The notice shall advise a provider:

1. That payments are being withheld in accordance with this administrative regulation;

2. The statutory and regulatory basis for withholding and the facts upon which the action is taken;

3. The date upon which withholding began;

4. That withholding shall be for a temporary period;

5. The circumstances under which withholding shall be discontinued;

6. The type of Medicaid claim, as appropriate, to which withholding shall apply;

7. The provider's right to submit written evidence for consideration by the department; and

8. The provider's administrative appeal process rights, if any, in accordance with Sections 8 and 9 of this administrative regulation.

(4) A withholding of payment action under this section shall be temporary and shall not continue after:

(a) The investigation has been discontinued due to insufficient evidence of fraud or willful misrepresentation by the provider;

(b) Legal proceedings related to the provider's alleged unacceptable practice are final and not subject to further appeal and court-ordered, deferred prosecution, or plea-bargained restitution has been paid; or

(c) The matter has been resolved between the department and the provider through an administrative determination of unacceptable practice, as specified in Section 3 of this administrative regulation.

(5) Upon completion of the process established in subsection (4)(a) and (b) of this section, all moneys withheld not otherwise used to offset a valid overpayment or court-ordered restitution, due on claims shall be promptly disbursed to a provider.

Section 5. Sanctions. (1) The department shall comply with the requirements of 42 CFR 1002 and 42 U.S.C. 1320a-7.

(2) The department shall impose sanctions as provided in KRS 205.8467 and Sections 3, 4, 5, and 6 of this administrative regulation.

(3) The department may hold, during its administrative determination of unacceptable practice, a provider responsible and liable for the conduct and actions of its affiliates, representatives, employees, or subcontractors. Conduct shall only be imputed to another if:

(a) The conduct was accomplished within the course of the duties of the provider to be sanctioned; and

(b) The provider had knowledge, if:

1. The provider knew or reasonably should have known of the conduct; or

2. The conduct was effected with the knowledge and consent of the provider.

(4) If the department sanctions a provider, it may also sanction an affiliate of the provider. A determination to sanction an affiliate shall be made during the process leading to the administrative determination of unacceptable practice, on a case-by-case basis, after full review and consideration of all relevant facts and circumstances leading to the sanction of the provider. An affiliate shall have the same notification, time limits to dispute, due process rights, and burden of proof as a provider.

(5) The sanction process may include a termination of a provider from the Medicaid Program. If a termination is made, the termination notice shall specify the period of exclusion. In determining the sanction, or the duration of exclusion, the department shall consider as appropriate:

(a) The number and nature of the unacceptable practice incidents;

(b) The nature and extent of the adverse impact the violations had on recipients;

(c) The amount of damages to the Medicaid Program;

(d) Past criminal records of activities involving a child, patient or adult in matters of abuse, neglect, sexual abuse, malpractice, or the personal involvement in fraud or another violation of 42 U.S.C. 1128a-b13, that may have been discovered as a result of the investigation of the unacceptable practice or other related material facts that may impact the health, safety and well-being of Medicaid recipients; and

(e) The previous record of violations by the provider under Medicare, Medicaid or other program administered by the department.

(6) The sanction process shall include liability for civil payments, restitution of overpayments and agency costs as specified in KRS 205.8467.

(7) The department shall use a lien, as specified in KRS 205.8471, to assure payment of restitution and monetary penalties imposed under the administrative determination of fraud.

(8) A provider excluded from the Medicare Program shall be excluded from the Medicaid Program for the same period of time.

(9) The provider shall be notified in writing by the department of the sanctions that are imposed pursuant to 42 CFR 1001.2002.

Section 6. Termination of Provider Participation. (1) Terminations and hearings.

(a) Before the participation of a nursing facility, as defined in 42 U.S.C. 1396r(a), or an intermediate care facility for the mentally retarded, as defined in 42 U.S.C. 1396d(d), is terminated, it shall have the right to receive an administrative hearing in accordance with Sections 8 and 9 of this administrative regulation and 42 CFR 431.151 through 431.154.

(b) Except as provided in paragraph (a) of this subsection, provider participation shall be terminated without prior hearing.

(2) A provider's participation may be terminated by either the provider or the department upon thirty (30) calendar days written notice to the other without cause or as otherwise specified in the provider agreement.

(3) A provider's participation may be terminated and a period of exclusion imposed, if an administrative determination is made, as established in Section 3 of this administrative regulation, that the provider engaged in an unacceptable practice.

(4) Except as provided for in 907 KAR 1:672, failure to maintain up-to-date information, or to submit the information within thirty-five (35) calendar days of a request by the department, shall result in termination of a provider's participation in the Medicaid Program.

(5) A provider's participation shall be terminated immediately, if it is determined that the information provided at the time of application or reinstatement was incorrect, inaccurate or incomplete and if provision of correct, accurate and complete information would have resulted in the denial of the application based upon one (1) or more of the factors established in 907 KAR 1:672 or this administrative regulation.

(6) A provider's participation may be terminated, if the provider fails or refuses to pay or enter into an agreement to pay the amount of a penalty imposed, including interest, in accordance with Section 5 of this administrative regulation and KRS 205.8467 within sixty (60) calendar days from the date of the department's notice or the date of a hearing decision, if they occur.

(7) A provider's participation in Medicaid shall be terminated, if the provider fails to submit a completed and signed application within thirty-five (35) calendar days from the date of the notice to provide the application.

(8) A provider's participation in Medicaid shall be terminated and a period of exclusion imposed upon a Medicare or Medicaid related conviction through the judicial process pursuant to 42 U.S.C. 1320a-7.

(9) A provider's participation in Medicaid shall be terminated in accordance with 42 CFR 1003.105 on the date of termination or suspension from Medicare.

(10) A provider's participation in Medicaid shall be terminated as of the date of a termination, revocation, or suspension of a registration, certification or license to practice a medical profession, or as required to provide medical care, services or supplies under Medicaid.

(11) A provider's participation in Medicaid shall be terminated and a new application required, if the ownership or controlling interest of the provider has substantially changed since the acceptance of the current enrollment application, which may include one (1) or more of the following actions:

(a) A sole proprietor transfers title and property to another party;

(b) The addition, removal, or substitution of one (1) or more partners of a provider organized as a partnership effects the termination of the partnership, and creates a successor partnership or other entity;

(c) An incorporated provider merges with an incorporated institution which is not participating in the program and the nonparticipating institution is the surviving corporation;

(d) Two (2) or more corporate providers consolidate and the consolidation results in the creation of a new corporate entity;

(e) Two (2) or more unincorporated providers consolidate;

(f) The sale, purchase, exchange of stock, merger or other consolidation of the business or assets directly related to the provision of health care, if the sale results in a change of ownership or control of a provider;

(g) If the ownership or controlling interest of the provider has substantially changed since the acceptance of its enrollment application regardless of reason; or

(h) A provider, or a person, or organization having direct or indirect ownership, or control interest in the disclosing entity as defined by 42 CFR 455.101 and 102, is listed, or required to be listed, on the current Medicaid enrollment application and has been convicted in a court of appropriate jurisdiction of criminal violations involving either a Medicare- or Medicaid-related offense and that conviction is final and not under appeal.

(12) The department may take into consideration its requirement to provide recipients adequate access to medical care, prior to an actual provider's termination from the Medicaid Program.

(13) A provider shall submit a minimum of one (1) Medicaid claim for payment for each provider number issued to that provider within twelve (12) consecutive months to have that number remain as "active" and in good status.

(14) Termination of inactive provider numbers. A provider shall be determined to have abandoned his provider number if twenty-four (24) consecutive months shall have expired without a claim being submitted upon that provider number to the department, or its fiscal agent for payment.

(15) The department may terminate a provider number and the provider's corresponding right to participate in the program for inactivity of billing if:

(a) A provider fails to submit the first claim upon the number initially issued to the provider within a period of twenty (24) months from the date the number was issued by the department, or its fiscal agent; or

(b) A provider number, that has had at least one (1) Medicaid claim submitted to the department, or its fiscal agent for payment, has no bill submitted for that number for twenty-four (24) consecutive months defined as:

1. When a period of twelve (12) consecutive months shall pass without a Medicaid claim being submitted for payment, the number shall be inactive; and

2. When a period of an additional twelve (12) consecutive months has passed with the number remaining inactive.

(16) A notice advising a provider of the termination and of the requirements to make a new application for enrollment shall be sent to the provider thirty (30) calendar days prior to his termination from the program, unless:

(a) Twenty (20) days shall have elapsed from the date of the notice of Medicaid exclusion pursuant to 42 CFR 1001.2002;

(b) Immediately required due to federal exclusion pursuant to 42 U.S.C. 1320a-7;

(c) Immediately required due to revocation or suspension of professional license or other action of:

1. A court of competent jurisdiction; or

2. The professional board governing the profession; or

(d) Otherwise required pursuant to this administrative regulation.

(17) Notice of termination.

(a) A notice of termination shall:

1. Be in writing;

2. Be mailed to a provider's last known mailing address;

3. State the reason for the termination;

4. State the effective date of the termination;

5. State the date the provider may submit an application for reenrollment, if appropriate;

6. State a provider's hearing rights, if any, in accordance with Sections 8 and 9 of this administrative regulation; and

7. Contain the basis of the exclusion, the length of the exclusion, the factors considered in setting the length of the exclusion, and the effect of the exclusion pursuant to 42 CFR 1001.2002, if the termination is the result of a federal or state sanction exclusion.

(b) If notice has been provided in accordance with Section 3 (5) of this administrative regulation, no additional notice of termination shall be required.

(18) The department may extend participation or waive termination for a provider of covered care, service or supply under the Medicaid Program, if necessary to assure that adequate access to Medicaid services will be available in the area served by the provider pursuant to 42 CFR 1396a(8).

(19) The department may terminate a provider immediately, if necessary to protect the health, safety, or well-being of Medicaid recipients.

Section 7. Provider Reinstatement or Reenrollment Following Termination. (1) A provider whose participation has been terminated under the provisions of this administrative regulation may request reinstatement in accordance with:

(a) The requirements established in the department's written provider application;

(b) The enrollment requirements pursuant to 907 KAR 1:672;

(c) Other requirements pursuant to this administrative regulation; and

(d) A written declaration of the provider’s request for reinstatement on the first page of the application form.

(2) The department may grant reinstatement from an exclusion based on a program violation, if the provider shall have:

(a) Demonstrated to the department that the violation which led to the sanction is corrected; or

(b) Otherwise established to the department's satisfaction that further violations will not be repeated.

(3) If the department approves a request for reinstatement after imposition of a sanction in accordance with Section 5 of this administrative regulation, the department shall provide written notice to the provider and to all others who were informed of the sanction, specifying the date on which program participation may resume. Participation by a provider, reinstated under this section, is conditional upon their compliance with their assurance of no further violations.

(4) A provider terminated from the Medicaid Program and excluded for a specified period of time shall be eligible for reenrollment upon the expiration of the period of exclusion. Providers excluded on the basis of a conviction for a Medicare- or Medicaid-related offense shall not be eligible for reenrollment until:

(a) The conviction shall be final and not under appeal;

(b) The specified period of exclusion shall have expired; and

(c) The provisions of subsections (1) and (2) of this section have been met.

(5) A provider that has an outstanding debt to the program shall not be reinstated or reapproved for Medicaid Program participation.

Section 8. Resolution of Provider Disputes Prior to Administrative Hearing. (1) If a provider disagrees with a Medicaid determination with regard to an appealable issue as provided for in Section 9 of this administrative regulation, the provider may request a dispute resolution meeting. The request shall be in writing and mailed to and received by the branch manager that initiated the department-written determination within thirty (30) calendar days of the date the notice was received by the provider. The department shall not accept or honor a request for administrative appeals process, or a part thereof, that is filed by a provider prior to receipt of the department-written determination that creates an administrative appeal right under this administrative regulation.

(2) A provider's request for a resolution meeting shall clearly:

(a) Identify each specific issue and dispute;

(b) State the basis on which the department's decision on each issue is believed to be erroneous;

(c) Provide documentation or a summary supporting the provider's position; and

(d) State the name, mailing address, and telephone number of individuals who are expected to attend the dispute resolution meeting on the provider's behalf.

(3) Either the department or the provider may request the presence of a court reporter at the dispute resolution meeting. A court reporter shall be secured in advance of the meeting, and a dispute resolution meeting shall not be postponed solely due to the failure to timely secure a court reporter.

(4) Except if the court reporter was requested solely by the provider, the department shall bear the cost of a court reporter. Each party shall at all times bear the costs of requested transcribed copies.

(5) Dispute resolution meetings involving a court reporter shall be conducted face to face, and shall not be conducted via telephone.

(6) If an administrative hearing is requested, the transcript shall become part of the official record of the hearing pursuant to KRS 13B.130.

(7) The department shall, within ten (10) calendar days of receipt of the request for a dispute resolution meeting, send a written response to the provider identifying the time and place in which the meeting shall be held within thirty (30) days of receipt of the request and identifying the department's representative who is expected to attend the meeting. The meeting shall be held within forty (40) calendar days of receipt of the request, unless a postponement is requested. The dispute resolution meeting may be postponed for a maximum additional period of sixty (60) calendar days, at the request of any party.

(8) The dispute resolution meeting shall be conducted in an informal manner as directed by the department's representative. The provider may present evidence or testimony to support his case. Each party shall be given an opportunity to ask questions to clarify the disputed issue or issues.

(9) A provider may, within the same deadline specified in subsection (1) of this section, submit information that the provider wishes to be considered in relation to the department's determination without requesting a dispute resolution meeting. The submission of additional documentation shall not extend the thirty (30) day time period for requesting a resolution meeting.

(10) The department, after the dispute resolution meeting, or the date the information to be considered was presented to the department as established in subsection (9) of this section, shall within thirty (30) calendar days:

(a) Uphold, rescind, or modify the original decision with regard to the disputed issue; and

(b) Provide written notice to the provider of the department's decision and the facts upon which it is based with reference to applicable statutes and administrative regulations.

(11) Information submitted for the purpose of informally resolving a provider dispute shall not be considered a request for an administrative hearing.

(12) The department may waive the dispute resolution meeting, at its sole discretion, and issue a decision in lieu of the meeting, with the decision subject to administrative hearing under Section 9 of this administrative regulation.

(13) The department may postpone the issuance of its findings of the dispute resolution meeting, or its review of the materials submitted in lieu of a dispute resolution meeting, by mailing a written notice to the provider stating the reason for the delay and the anticipated date of completion of the review. A postponement shall not extend beyond 180 days.

Section 9. Administrative Hearing. (1) The administrative hearing shall be conducted in accordance with KRS Chapter 13B by a hearing officer who is knowledgeable of Medicaid policy, as established in federal and state laws.

(2) The secretary of the cabinet, pursuant to KRS 13B.030(1), shall delegate by administrative order conferred powers to conduct administrative hearings under this administrative regulation.

(3) The department, in addition to Section 8(1) of this administrative regulation, shall not accept or honor a request for administrative appeals process, or a part thereof, by a provider that is:

(a) Filed at the state level for a federal-mandated exclusion subsequent to a federal notice of the exclusion containing the federal appeal rights; or

(b) Filed at the state level for program exclusion resulting from a criminal conviction by the court of competent jurisdiction, upon exhaustion or failure to timely pursue the judicial appeal process.

(4) The administrative hearing process shall be used in the following situations:

(a) If a provider is a nursing facility as defined in 42 U.S.C. 1396r(a), or is an intermediate care facility for the mentally retarded as defined in 42 U.S.C. 1396d(d), and participation is terminated regardless of reason;

(b) A provider alleges discrimination by the department as prohibited by 42 U.S.C. 2000d;

(c) The department imposes a sanction;

(d) The department requires repayment of a noncourt-established overpayment or noncourt-ordered restitution; or

(e) A provider's payments are being withheld in accordance with Section 4 of this administrative regulation.

(5) A written request for an administrative hearing shall be received by the department within thirty (30) calendar days of the date of receipt of the department's notice of a determination or a dispute resolution decision. This request shall be sent to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Health and Family Services, 275 East Main Street, 6th Floor, Frankfort, Kentucky 40621-0002.

(6) The department shall forward to the hearing officer an administrative record which shall include the notice of action taken, the statutory or regulatory basis for the action taken, the department's decision following the resolution process, and all documentary evidence provided by the provider, his billing agent, subcontractor, fiscal agent or another provider-authorized individual to the department.

(7) The notice of the administrative hearing shall comply with KRS 13B.050.

(a) The administrative hearing shall be held in Frankfort, Kentucky no later than sixty (60) calendar days from the date the request for the administrative hearing is received by the department.

(b) The administrative hearing date may be extended beyond the sixty (60) calendar days by:

1. A mutual agreement by the provider and the department; or

2. A continuance granted by the hearing officer.

(8) If a prehearing conference is requested, it shall be held at least seven (7) calendar days in advance of the hearing date. Conduct of the prehearing conference shall comply with KRS 13B.070.

(9) If a provider does not appear at the hearing on the scheduled date and the hearing has not been previously rescheduled, the hearing officer may find a provider in default pursuant to KRS 13B.050(3)(h). A hearing request shall be withdrawn only under the following circumstances:

(a) The hearing officer receives a written statement from a provider stating that the request is withdrawn; or

(b) A provider makes a statement on the record at the hearing that he is withdrawing his request for the hearing.

(10) Documentary evidence to be used at the hearing shall be made available in accordance with KRS 13B.090.

(11) Information relating to the selection of the provider for audit, investigation notes or other materials which may disclose auditor investigative techniques, methodologies, material prepared for submission to a law enforcement or prosecutorial agency, information concerning law enforcement investigations, judicial proceedings, confidential sources or confidential information shall not be revealed, unless exculpatory in nature as required pursuant to KRS 13B.090(3).

(12) A hearing officer shall preside over the hearing and shall conduct the hearing in accordance with KRS 13B.080 and 13B.090.

(13) The issues considered at a hearing shall be limited to:

(a) Issues directly raised in the initial request for a dispute resolution meeting;

(b) Issues directly raised during the disputed resolution meeting; or

(c) Materials submitted in lieu of a dispute resolution meeting.

(14) KRS 13B.090(7) shall govern the burdens of proof.

(a) The department shall have the initial burden of showing the existence of the administrative regulations or statutes upon which the determination was based.

(b) If the determination is based upon an alleged failure of a provider to comply with applicable generally accepted business, accounting, professional, chiropractic or medical practices or standards of health care, the department shall establish the existence of the practice or standard.

(c) The department shall be responsible for notifying the hearing officer of previous relevant violations by the provider under Medicare, Medicaid, or other program administered by the Cabinet for Health and Family Services, or relevant prior actions under Section 5(5) of this administrative regulation, which the department wishes the hearing officer to consider in his deliberations.

(15) The hearing officer shall issue a recommended order in accordance with KRS 13B.110.

(16) Except for the requirement that the request for the administrative appeal process, or a part thereof, be filed in a timely manner, the hearing officer may grant an extension of time specified in this section, if determined necessary for the efficient administration of the hearing process or to prevent an obvious miscarriage of justice with regard to the provider. An extension of time for completion of the recommended order shall comply with the requirements of KRS 13B.110(2) and (3).

(17) A final order shall be entered in accordance with KRS 13B.120.

(18) The cabinet shall maintain an official record of the hearing in compliance with KRS 13B.130.

(19) In the correspondence transmitting the final order, clear reference shall be made to the availability of judicial review pursuant to KRS 13B.140 and 13B.150

Section 10. Actions Taken at the Conclusion of the Administrative Appeal Process. (1) The stay on recoupment granted under Section 2(10)(b) of this administrative regulation shall not extend to judicial review, unless a stay is granted pursuant to KRS 13B.140(4).

(2) If during an administrative appeal process circumstances require a new or modified determination letter, new appeal rights shall be provided in accordance with this administrative regulation.

(3) Thirty (30) calendar days after the issuance of the final order pursuant to KRS 13B.120, the department:

(a) Shall initiate collection activities, and take all lawful actions to collect the debt; and

(b) May enact program terminations, sanctions pursuant to 42 U.S.C. 1320a-7, or other actions that were held in abeyance pending the decision of the administrative appeal process. (21 Ky.R. 2346; Am. 3043; 22 Ky.R. 73; eff. 6-21-95; 2178; eff. 7-5-96; 26 Ky.R. 137; eff. 7-17-2000; 28 Ky.R. 975; 1422; eff. 12-19-2001.)

907 KAR 1:672

http://www.lrc.ky.gov/kar/907/001/672.htm

907 KAR 1:672. Provider enrollment, disclosure, and documentation for Medicaid participation.

RELATES TO: KRS 205.520, 205.560, 205.8451(2),(7),(8),(9), 205.8477, 304.17A-545(5), 311.621-311.643, 42 U.S.C. 1396a(w), 42 C.F.R. 455.100-455.106, 42 C.F.R. 1003.101

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(12), 42 U.S.C. 1396a, b, c

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. KRS 205.560(12) requires the Medical Assistance Program to use the form and guidelines established pursuant to KRS 304.17A-545(5) for assessing the credentials of those applying for participation in the Medical Assistance Program. KRS 205.560(13) requires the department to develop a specific form and establish guidelines for assessing the credentials of dentists applying for participation in the Medical Assistance Program. This administrative regulation establishes provisions related to Medicaid provider enrollment, disclosure, documentation requirements, and guidelines for assessing the credentials of those applying for participation in the Medicaid Program.

Section 1. Definitions. (1) "Applicant" means a person or entity who applies for enrollment as a participating Medicaid provider.

(2) "Cabinet" means the Cabinet for Health and Family Services.

(3) "Claim" means a request for payment under the Medicaid Program that:

(a) Relates to each individual billing submitted by a provider to the department;

(b) Details services rendered to a recipient on a specific date; and

(c) May be a line item of service or all services for one (1) recipient on a bill.

(4) "Credentialed provider" means a provider that is required to complete the credentialing process in accordance with KRS 205.560(12) and (13) and includes the following individuals who apply for enrollment in the Medicaid Program:

(a) A dentist;

(b) A physician;

(c) An audiologist;

(d) A certified registered nurse anesthetist;

(e) An optometrist;

(f) An advance registered nurse practitioner;

(g) A podiatrist;

(h) A chiropractor; or

(i) A physician assistant.

(5) "Department" means the Department for Medicaid Services or its designated agent.

(6) "Disclosure" means the provision of information required by 42 C.F.R. 455.100 through 455.106.

(7) "Evaluation" or "credentialing" means:

(a) A process for collecting and verifying professional qualifications of a health care provider;

(b) An assessment of whether a health care provider meets specified criteria relating to professional competence and conduct; and

(c) A process to be completed before a health care provider may participate in the Medicaid Program on an initial or ongoing basis.

(8) "Exclusion" is defined by 42 C.F.R. 1003.101.

(9) "Furnish" means to provide medical care, services, or supplies that are:

(a) Provided directly by a provider;

(b) Provided under the supervision of a provider; or

(c) Prescribed by a provider.

(10) "Managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or conducts the day-to-day operation of an institution, entity, organization, or agency.

(11) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(12) "Noncredentialed provider" means a provider that is not required to complete the credentialing process in accordance with KRS 205.560(12) and includes any individual or entity not identified in subsection (4) of this section.

(13) "Provider" is defined by KRS 205.8451(7).

(14) "Recipient" is defined by KRS 205.8451(9).

(15) "Reevaluation" or "recredentialing" means a process for identifying a change that may have occurred in a health care provider since the last evaluation or credentialing that may affect the health care provider's ability to perform services.

(16) "Services" means medical care, services, or supplies provided to a Medicaid recipient.

(17) "Subcontractor" means an individual, agency, entity, or organization to which a Medicaid provider or the department's fiscal agent has:

(a) Contracted or delegated some of its management functions or responsibilities of providing medical care or services to its patients; or

(b) Entered into a contract, agreement, purchase order, or lease, including lease of real property, to obtain space, supplies, equipment, or nonmedical services associated with providing services and supplies that are covered under the Medicaid Program.

(18) "Terminated" means a provider's participation in the Medicaid Program has ended and a contractual relationship no longer exists between the provider and the department for the provision of Medicaid-covered services to eligible recipients by the provider or its subcontractor.

(19) "Unacceptable practice" means conduct by a provider which constitutes "fraud" or "provider abuse", as defined in KRS 205.8451(2) or (8), or willful misrepresentation, and includes the practices specified in Section 5 of this administrative regulation.

Section 2. Enrollment Process for Provider Participation in Medicaid. (1) Scope.

(a) The department shall contract only with an individual or entity who meets the conditions of Medicaid provider participation in accordance with 907 KAR 1:671.

(b) The department shall reserve the right to contract or not contract with any potential provider.

(c) An individual or entity that wishes to participate:

1. in the Medicaid Program shall be enrolled as a participating provider prior to being eligible to receive reimbursement in accordance with federal and state laws; and

2. As a KenPAC primary care provider shall meet the provider participation criteria established in 907 KAR 1:320, Kentucky Patient Access and Care System (KenPAC).

(2) To apply for enrollment in the Medicaid Program as a noncredentialed provider, an individual or entity shall:

(a) Complete, and submit to the department, the noncredentialed provider section of a MAP-811, Provider Application; and

(b) Submit of a valid professional license, registration, or certificate that allows the:

1. Individual to provide services within the individual's scope of practice; or

2. Entity to operate or provide services within the entity's scope of practice.

(3) To apply for enrollment in the Medicaid Program as a credentialed provider, an individual shall:

(a) Complete, and submit to the department, the individual provider application section of a MAP-811, Provider Application;

(b) Submit proof of a valid professional license, registration, or certificate that allows the individual to provide services within the individual's scope of practice; and

(c)1. Except for a dentist, submit either:

a. A completed KAPER-1, Kentucky Application for Provider Evaluation and Reevaluation; or

b. Pursuant to 806 KAR 17:480, Section 2(4), the provider application form of the Council for Affordable Quality Healthcare; or

2. If licensed to practice as a dentist, submit a completed Dental Credentialing Form.

(4)(a) Within forty-five (45) days of recept of a required credentialing form, the department shall notify the health care provider or entity applying for enrollment in the Medicaid Program of any omitted information or questionable information included on the form.

(b) The department shall deny enrollment if the applicant does not:

1. Respond with the requested information within the time period specified in the department’s notice of omitted or questionnaire information; or

2. Requests an extension of time that is:

a. Requested during the time period specified in the department’s notice; and

b. Grant by the department..

(c) The department may require that an on-site inspection be performed to ascertain compliance with applicable licensure standards established in KRS Chapter 216B, and certification standards, prior to an enrollment determination.

(d)1. The department shall make an enrollment determination within ninety (90) days of receipt of:

a. The completed application documents required by subsection (2) or (3) of this section; and

b. Any additional information requested by the department.

2. The department:

a. May take additional time beyond ninety (90) days to render a decision if necessary for resolution of an issue or dispute; and

b. Shall notify the applicant that a decision will be issued after the ninety (90) day timeframe established in subparagraph 1 of this paragraph if additional time is needed to render a decision.

(5) Approval of enrollment in the Medicaid Program as a participating provider.

(a) Upon approval of enrollment, the department shall issue a provider number that shall be used by the provider solely for billing and identification purposes.

(b) A provider's participation shall begin and end on the dates specified in the notification of approval for program participation, unless the provider's participation is terminated in accordance with this administrative regulation, 907 KAR 1:671, or other applicable state or federal laws.

(6) By enrolling in the Medicaid Program, a provider, the provider's officers, directors, agents, employees, and subcontractors agree to:

(a) Maintain the documentation for claims as required by Section 4 of this administrative regulation;

(b) Provide, upon request, all information regarding the nature and extent of services and claims submitted by, or on behalf of the provider, to the:

1. Cabinet;
2. Department;
3. Attorney General;
4. Auditor of Public Accounts;
5. Secretary of the United States Department of Health and Human Services; or
6. Office of the United States Attorney;

(c) Comply with the disclosure requirements established in Section 3 of this administrative regulation;

(d) Comply with the applicable advance directive requirements established in 42 U.S.C. 1396a(w) regarding the right to accept or reject life-saving medical procedures as described in KRS 311.621 through 311.643;

(e) Accept payment from Medicaid as payment in full for all care, services, benefits, or and supplies billed to the Medicaid Program, except with regard to recipient cost-sharing charges and beneficiary liability, if any;

(f) Submit claims for payment only for care, services, benefits, or supplies;

1. Actually furnished to eligible recipients; and
2. Medically necessary or otherwise authorized by law;

(g) Provide true, accurate, and complete information in relation to any claim for payment;

(h) Permit review or audit of all books or records or, at the discretion of the auditing agency, a sample of books or records related to services furnished and payments received from Medicaid, including recipient histories, case files, and recipient specific data.

Failure to allow access to records may result in the provider's liability for costs incurred by the cabinet associated with the review of records, including food, lodging and mileage;

(i) Not engage in any activity that would constitute an unacceptable practice;

(j) Comply with all terms and provisions contained in the application documents required by subsection (2) or (3) of this section;

(k) Comply with all applicable federal laws, state statutes, and state administrative regulations related to the applicant's provider type and provision of services under the Medicaid Program; and

(l) Bill third party payers in accordance with Medicaid statutes and administrative regulations.

(7) Denial of enrollment or reenrollment in the Medicaid Program.

(a) The department shall deny enrollment if an applicant meets one (1) of the following conditions:

1. Falsely represents, omits, or fails to disclose of any material fact in making an application for enrollments in accordance with subsection (2) or (3) of this section;
2. Is currently suspended, excluded, terminated, or involuntarily withdrawn from participation in any governmental medical insurance program as a result of fraud or abuse of that program;
3. Falsely represents, omits, or fails to disclose any material fact in making an application for a license, permit, certificate, or registration related to a health care profession or business;
4. Has failed to comply with applicable standards in the operation of a health care business or enterprise after having received written notice of noncompliance from:
   a. The department; or
   b. A state or federal licensing, certifying, or auditing agency;

5. Is under current investigation, indictment or conviction for fraud and abuse or unacceptable practice in:

a. The Kentucky Medicaid Program;

b. Another state's Medicaid Program;

c. The Medicare Program; or

d. Other publicly funded health care program;

6. Fails to comply with any Medicaid policy as specified in the Kentucky statutes or department's administrative regulations;

7. Fails to pay any outstanding debt owed to the department; or

8. Has engaged in an activity that would constitute an unacceptable practice.

(b) If enrollment or reenrollment is denied, the department shall consider reapplication only:

1. If the applicant corrects each deficiency that led to the denial; and

2. After the expiration of a period of exclusion imposed in accordance with 907 KAR 1:671, if applicable.

(c) Notice of denial of enrollment or reenrollment. The department shall send written notice of denial to an applicant's last known address and provide the reason for the denial.

(d) The denial shall be effective upon the date of the written notice.

(8)1. A provider may request limited enrollment for a period of time, not to exceed thirty (30) days, in an exceptional situation for emergency services provided to an eligible recipient.

2. The department shall make an enrollment determination regarding the exceptional circumstances and notify the provider in writing of its decision.

(9) Recredentialing. A credentialed provider currently enrolled in the Medicaid Program shall submit to the department's recredentialing process three (3) years from the date of the provider's initial evaluation or last reevaluation.

Section 3. Required Provider Disclosure. (1) A provider shall comply with the disclosure of information requirements contained in 42 C.F.R. 455.100 through 455.106 and KRS 205.8477.

(2) Time and manner of disclosure. Information disclosed in accordance with 42 C.F.R. 455.100 through 455.106 shall be provided:

(a) Upon application for enrollment;

(b) Annually thereafter; and

(c) Within thirty-five (35) days of a written request by the department or the United States Department of Health and Human Services.

(3) If a provider fails to disclose information required by 42 C.F.R. 455,.100 through 455.106 within thirty-five (35) days of the department's written request, the department shall terminate the provider's participation in the Medicaid Program in accordance with 907 KAR 1:671, Section 6, on the day following the last day for submittal of the required information.

(4)(a) A provider shall file an amended, signed ownership and disclosure form with the department within thirty-five (35) days following a change in:

1. Ownership or control;

2. The managing employee or management company; or

3. A provider's federal tax identification number.

(b) Failure to comply with the requirements of paragraph (a) of this subsection may result in termination from the Medicaid Program.

Section 4. Required Provider Documentation. (1) A provider shall maintain documentation of:

(a) Care, services, benefits, or supplies provided to an eligible recipient;

(b) The recipient's medical record or other provider file, as appropriate, which shall demonstrate that the care, services, benefits, or supplies for which the provider submitted a claim were actually performed or delivered;

(c) The diagnostic condition necessitating the service performed or supplies provided; and

(d) Medical necessity as substantiated by appropriate documentation including an appropriate medical order.

(2) A provider who is reimbursed using a cost-based method shall maintain all:

(a) Fiscal and statistical records and reports used for the purpose of establishing rates of payment made in accordance with Medicaid requirements established in 907 KAR Chapters 1, 3, and 4, as applicable; and

(b) Underlying books, records, documentation and reports that formed the basis for the fiscal and statistical records and reports.

(3) All documentation required by this section shall be maintained by the provider for a minimum of five (5) years from the latter of:

(a) The date of final payment for services;

(b) The date of final cost settlement for cost reports; or

(c) The date of final resolution of disputes, if any.

(4) If any litigation, claim, negotiation, audit, investigation, or other action involving the records started before expiration of the five (5) year retention period, the records shall be retained until the latter of:

(a) The completion of the action and resolution of all issues which arise from it; or

(b) The end of the regular five (5) year period.

Section 5. Unacceptable Practice. The activities listed in this section shall constitute unacceptable practice:

(1) Knowingly submitting, or causing the submission of false claims, or inducing, or seeking to induce, a person to submit false claims;

(2) Knowingly making, or causing to be made, or inducing, or seeking to induce a false, fictitious or fraudulent statement or misrepresentation of material fact in claiming a Medicaid payment, or for use in determining the right to payment;

(3) Having knowledge of an event that affects the right of a provider to receive payment and concealing or failing to disclose the event or other material omission with the intention that a payment be made or the payment is made in a greater amount than otherwise owned;

(4) Conversion;

(5) Soliciting or accepting bribes or kickbacks;

(6) Failing to maintain or to make available, for purposes of audit or investigation, administrative and medical records necessary to fully disclose the medical necessity for the nature and extent of the medical care, services and supplies furnished, or to comply with other requirements established in 907 KAR 1:673, Section 2;

(7) Knowingly submitting a claim or accepting payment for medical care, services, or supplies furnished by a provider who has been terminated or excluded from the program;

(8) Seeking or accepting additional payments, for example, gifts, money, donations, or other consideration, in addition to the amount paid or payable under the Medicaid Program for covered medical care, services, or supplies for which a claim is made;

(9) Charging or agreeing to charge or collect a fee from a recipient for covered services which is in addition to amounts paid by the Medicaid Program, except for required copayments recipient liability, if any, required by the Medicaid Program;

(10) Engaging in conspiracy, complicity, or criminal syndications;

(11) Furnishing medical care, services, or supplies that fail to meet professionally recognized standards, or which are found to be non compliant with licensure standards promulgated under KRS Chapter 216B and failing to correct the deficiencies or violation as reported to the department by the Office provider's professional qualifications or licensure;

(12) Discriminating in the furnishing of medical care, services, or supplies as prohibited by 42 U.S.C. 2000d;

(13) Having payments made to or through a factor, either directly or by power of attorney, as prohibited by 42 C.F.R. 447.10;

(14) Offering or providing a premium or inducement to a recipient in return for the recipient's patronage of the provider or other provider to receive medical care, services, or supplies under the Medicaid Program;

(15) Knowingly failing to meet disclosure requirements;

(16) Unbundling; or

(17) An act committed by a nonprovider on behalf of a provider which, if committed by a provider, would result in the termination of the provider's enrollment in the program.

Section 6. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Kentucky Application for Provider Evaluation and Reevaluation", Form KAPER-1, March 2007 edition;

(b) "Map-811, Provider Application", July 2007 edition;

(c) "Dental Credentialing form", July 2007 edition; and

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (22 Ky.R. 2198; eff. 7-5-96; 34 Ky.R. 446; 1040; 1470; eff. 1-4-2008.)

42 CFR 455.101

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455.101 Definitions.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);

(b) Any Medicare intermediary or carrier; and

(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Health insuring organization (HIO) has the meaning specified in § 438.2.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managed care entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that—

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;

(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

(e) Is an officer or director of a disclosing entity that is organized as a corporation; or

(f) Is a partner in a disclosing entity that is organized as a partnership.

Prepaid ambulatory health plan (PAHP) has the meaning specified in § 438.2.

Prepaid inpatient health plan (PIHP) has the meaning specified in § 438.2.

Primary care case manager (PCCM) has the meaning specified in § 438.2.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means—

(a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Termination means—

(1) For a—

(i) Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and

(ii) Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired.

(2)(i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary.

(ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.

(3) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to—

(i) Fraud;

(ii) Integrity; or

(iii) Quality.

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

[44 FR 41644, July 17, 1979, as amended at 51 FR 34788, Sept. 30, 1986; 76 FR 5967, Feb. 2, 2011]

42 CFR 455.104

www.ecfr.gov

455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.

(a) *Who must provide disclosures.* The Medicaid agency must obtain disclosures from disclosing entities, fiscal agents, and managed care entities.

(b) *What disclosures must be provided.* The Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures:

(1)(i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

(ii) Date of birth and Social Security Number (in the case of an individual).

(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

(2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

(3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

(c) *When the disclosures must be provided.*

(1) *Disclosures from providers or disclosing entities.* Disclosure from any provider or disclosing entity is due at any of the following times:

(i) Upon the provider or disclosing entity submitting the provider application.

(ii) Upon the provider or disclosing entity executing the provider agreement.

(iii) Upon request of the Medicaid agency during the re-validation of enrollment process under § 455.414.

(iv) Within 35 days after any change in ownership of the disclosing entity.

(2) *Disclosures from fiscal agents.* Disclosures from fiscal agents are due at any of the following times:

(i) Upon the fiscal agent submitting the proposal in accordance with the State's procurement process.

(ii) Upon the fiscal agent executing the contract with the State.

(iii) Upon renewal or extension of the contract.

(iv) Within 35 days after any change in ownership of the fiscal agent.

(3) *Disclosures from managed care entities.* Disclosures from managed care entities (MCOs, PIHPs, PAHPs, and HIOs), except PCCMs are due at any of the following times:
(i) Upon the managed care entity submitting the proposal in accordance with the State's procurement process.
(ii) Upon the managed care entity executing the contract with the State.
(iii) Upon renewal or extension of the contract.
(iv) Within 35 days after any change in ownership of the managed care entity.
(4) *Disclosures from PCCMs.* PCCMs will comply with disclosure requirements under paragraph (c)(1) of this section.
(d) *To whom must the disclosures be provided.* All disclosures must be provided to the Medicaid agency.
(e) *Consequences for failure to provide required disclosures.* Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.
[76 FR 5967, Feb. 2, 2011]

42 CFR 455.105

www.ecfr.gov

455.105 Disclosure by providers: Information related to business transactions.
(a) *Provider agreements.* A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section.
(b) *Information that must be submitted.* A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about—
(1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
(2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.
(c) *Denial of Federal financial participation (FFP).* (1) FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under § 420.205 of this chapter (Medicare requirements for disclosure).
(2) FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.

KRS 205.8477

205.8477 Ownership reporting requirements for health facilities and health services.

(1) Each health facility and health service as defined in KRS 216B.015 and each provider, participating in the Medical Assistance Program shall, as a condition of participation in the Medical Assistance Program, file annually with the Cabinet for Health and Family Services the names and addresses of all persons having direct or indirect ownership or control interest, as defined in 42 C.F.R. 455.101, with five percent (5%) or more interest in the health facility, or health service or the business of the provider and those Medical Assistance Program participating health facilities or health services with which the reporting provider, or health facility, or health service engages in a significant business transaction or a series of transactions that during any one (1) fiscal year, exceed the lesser of twenty-five thousand dollars ($25,000) or five percent (5%) of the total operating expenses of the provider, or health facility, or health service. The list of names and addresses shall be made available by the cabinet for public inspection during regular business hours and shall be updated annually.

(2) Each owner of or direct financial investor in any health facility or health service which dispenses or supplies drugs, medicines, medical devices, or durable medical equipment to a patient shall annually file with the Cabinet for Health and Family Services the names and addresses of any immediate family member who is authorized under state law to prescribe drugs or medicines or medical devices or equipment.

Effective: June 20, 2005

History: Amended 2005 Ky. Acts ch. 99, sec. 285, effective June 20, 2005. -- Amended 1998 Ky. Acts ch. 426, sec. 232, effective July 15, 1998. -- Created 1994 Ky. Acts ch. 96, sec. 14, effective July 15, 1994; and ch. 316, sec. 14, effective July 15, 1994.